

DENTAL ADMINISTRATIVE SERVICES CONTRACT

This Contract is entered into between **Snowflake Inc.** (Contractholder) and **Delta Dental of California** (hereinafter referred to as Delta Dental).

Whereas, Contractholder has adopted an employee dental benefit plan (the Plan, as defined below), which is set forth in the Employee Benefit Booklet, as shown in Section 7, mutually agreed upon by Contractholder and Delta Dental, and for which Contractholder retains all liabilities not otherwise identified in this Contract;

Whereas, Contractholder has requested Delta Dental to provide certain administrative services to the Plan and Delta Dental has agreed to provide such services in accordance with this Contract and, without assuming any liability of the Contractholder under the Plan not otherwise identified in this Contract;

Now therefore, in consideration of the mutual promises and covenants contained in this Contract, it is hereby agreed as follows:

SECTION 1. DEFINITIONS

Terms with capital letters appearing in this Contract shall have the meaning given to them in the Plan attached hereto as shown in Section 7. In addition, the following terms shall have these meanings:

- 1.01 **Contract** means this agreement between Delta Dental and Contractholder including the attached appendices, endorsements and riders, if any. This Contract constitutes the entire agreement between the parties.
- 1.02 **Contract Term** means the period during which this Contract is in effect. The Contract Term is shown in Appendix A.
- 1.03 **Plan** means the self-funded dental benefits program for Contractholder's employees or members and their eligible dependents as set forth in the appendices identified in Section 7 and incorporated into this Contract.

SECTION 2. DUTIES OF DELTA DENTAL

For the administrative charge set forth in Appendix A, Delta Dental will provide Contractholder with the following services for the administration and operation of the Plan:

2.01 **Claims Services**

Delta Dental shall provide the following claim services:

- a) Evaluate and process claims presented for Benefits described in the employee dental benefit booklet or Contractholder's dental section of its summary plan description approved by Delta Dental and Contractholder. Claims shall be processed in accordance with Delta Dental's standard processing policies and the employee dental plan booklet as shown in Section 7 of this Contract or Contractholder's dental section of its summary plan description approved by Delta Dental. Services shall not be covered when received by a patient who is not an Enrollee at the time of treatment except for Single Procedures started while the patient was covered. Proof of loss must be furnished to Delta Dental within twelve (12) months after care is received. Failure to furnish proof of loss within this time period shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss within such time and that such proof of loss was furnished as soon as reasonably possible. Proof of loss must be given no later than twelve (12) months from such time (unless the claimant was legally incapacitated). All written proof of loss must be given to Delta Dental within twelve (12) months of the termination of the Contract.
- b) Predetermine the amount of Benefits payable under the Contract. Pre-Treatment Estimate will be valid for twelve (12) months from the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:
 - the date this Contract terminates;
 - the date the Enrollee's coverage ends; or
 - the date the Delta Dental Premier® Provider's (Premier Provider) or Delta Dental PPO Provider's (PPO Provider) agreement with Delta Dental ends.

- c) Investigate claims when appropriate. This includes, but is not limited to, referring claims to professional consultants. In addition, Delta Dental may obtain to the extent permitted by law, from any Provider or from hospitals in which a Provider's care is provided, such information and records relating to an Enrollee as Delta Dental may require to determine the claim, or Delta Dental may require that an Enrollee be examined by a dental consultant retained by Delta Dental in or near the Enrollee's community or residence. Such information and records will be kept confidential.
- d) Coordinate Benefit coverage when Benefits are being provided under two (2) or more group benefit plans or group health care programs as described in the Employee Benefit Booklet prepared by Delta Dental and approved by Contractholder or Contractholder's dental section of its summary plan description approved by Delta Dental.
- e) Delta Dental may suspend claims for Enrollees if it does not receive all amounts due, in the amount and manner required by Section 3 and Appendix A. Also, Delta Dental shall not pay claims for any person unless included on the monthly eligibility list when the dental services are performed. However, a child shall be covered if notice of birth and payment are received within 31 days after birth. All payments for services performed by a PPO or Premier Provider will be made directly to the Provider. All other payments will be payable to the Primary Enrollee, or to the 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 may be payable to an individual legally supporting the person.
- f) Document claim payments to Providers for the purpose of reporting to the Internal Revenue Service.
- g) Furnish to any Provider or any Enrollee, on request, a Claim Form to make a claim for payment for services under the Plan.
- h) Notify the Primary Enrollee if any Benefits are denied for services submitted on a Claim Form. An Enrollee has 180 days after receiving a notice of denial to appeal it by writing to Delta Dental giving reason why the denial is disputed. The Enrollee may also ask Delta Dental to examine any records to aid an appeal. Delta Dental will review the denial in accordance with the Plan and render a decision.
- i) Provide Contractholder with an annual projection of paid claims.
- j) Provide Contractholder with standard claim activity reports.

2.02 **Employee Benefit Booklet**

Delta Dental shall be responsible for drafting an Employee Benefit Booklet which summarizes the Benefits and to whom Benefits are payable. Delta Dental is also responsible for providing this booklet to the Contractholder in an electronic format.

The booklet is non-assignable and the Benefits are non-assignable with the exception of payment of a claim to a PPO or Premier Provider or as required by law. If any amendment to this Contract shall materially affect any Benefits described in such booklet, Delta Dental will issue new booklets and amendments showing the change.

2.03 **Identification Card**

Delta Dental will mail identification cards to all Primary Enrollees to their home address and will make identification cards available for Primary Enrollees to download from Delta Dental's website (deltadentalins.com).

2.04 **PPO Providers and Premier Providers**

Delta Dental will provide access to PPO Provider and Premier Provider network listings on the Internet. Delta Dental's website address is deltadentalins.com. Delta Dental shall provide Contractholder with an electronic version of the PPO Provider Directory.

- a) Contractholder understands and agrees that any agreement between Delta Dental and a Provider in a Delta Dental network is that of an independent contractor. Delta Dental shall not be responsible for any care rendered or not rendered by a Provider.
- b) Any information relating to PPO Providers and Premier Providers will be considered the sole property of Delta Dental and shall not be distributed to third parties or for any

purpose other than one which is reasonably necessary to carry out the terms of the Contract.

- c) Delta Dental does not guarantee the availability of any Provider nor is it required that dental services be provided by any specific Provider.

SECTION 3. DUTIES OF CONTRACTHOLDER

3.01 Eligibility

On or before the Effective Date, Contractholder will furnish to Delta Dental, in writing or in electronic media format agreed by Delta Dental and the Contractholder, a listing of eligible Primary Enrollees and Dependent Enrollees. The listing must show the names, Enrollee ID numbers, dates of hire, dates of birth, dependent status and location codes, if any. The eligibility list shall include all active employees unless the employee waives coverage in writing or the Eligible Employee enrolls in an alternate dental plan offered by Contractholder.

Thereafter, before the 10th of each month, Contractholder must furnish to Delta Dental in the format agreed to above, a listing indicating specific additions, changes or terminations made during the prior month.

Contractholder will notify Delta Dental in writing of any requests for administrative fee adjustments for Enrollees who should have been terminated in the event Delta Dental was not previously notified of the termination(s). Said termination date will be adjusted retroactively to the immediately preceding three (3) months plus the current month, provided:

- a) no claims were submitted to be processed on said Enrollee subsequent to the date of retroactive termination; and
- b) The administrative fees were actually paid for the Enrollee subsequent to the date of retroactive termination.

Delta Dental will notify the Contractholder in writing of the revised termination date and administrative fees will be adjusted accordingly.

Delta Dental will not pay any Benefits for an Enrollee or Dependent Enrollee if proof of eligibility is not submitted. Also, Delta Dental will not pay Benefits for an Enrollee if the administrative fees are not paid for the month in which dental services are rendered.

3.02 Audits

Contractholder shall permit Delta Dental to audit its records to determine whether the lists of Primary Enrollees are correct, to prevent fraudulent enrollment, and to verify the monthly payments match the administrative charges. Delta Dental shall give Contractholder written notice within a reasonable time before the audit date.

3.03 Printing and Distribution

Contractholder agrees to consult with Delta Dental to the extent reasonably practical concerning any material published or distributed relating to the Contract. No such material shall be published or distributed which is contrary to the terms of the Contract.

Contractholder will make the Employee Benefit Booklet drafted by Delta Dental available to each Primary Enrollee via its internal computer network or through its website. Contractholder will neither change nor revise the Employee Benefit Booklet without the prior written approval of Delta Dental.

3.04 Electronic Transfer of Funds

Delta Dental will produce a summary of administrative fees, claims paid and other payments due to providers for services rendered, which may include, but are not limited to, any value-based care, pay for performance or other incentive payments to participating providers, for which Contractholder is responsible. Delta Dental will transmit the summary by notification to the Contractholder.

Delta Dental will initiate the Automatic Clearing House Debit against the designated bank account to reimburse Delta Dental for the payments in the summary within three (3) business days of sending the notification of the summary.

Delta Dental may suspend claims payments at any time if the requested electronic funds transfer is not received within the allotted time frame.

SECTION 4. RELATIONSHIP OF THE PARTIES

4.01 Delta Dental and Contractholder are independent contractors for the purposes of this Contract.

4.02 Delta Dental shall be responsible for fulfilling its administrative duties and obligations as set forth in this Contract. Notwithstanding the foregoing, Delta Dental may, in its discretion, delegate one or more functions or tasks to one or more subsidiaries or affiliated companies (companies under common control with or by Delta Dental). Such delegation shall not in any way affect Delta Dental's continuing obligation to perform its stated duties and obligations under this Contract.

4.03 Indemnification

Contractholder shall indemnify, defend and hold harmless Delta Dental, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Contract.

Delta Dental shall indemnify, defend and hold harmless the Contractholder, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Delta Dental's negligent performance or non-performance of its obligations under this Contract.

4.04 Impossibility of Performance and Force Majeure

Neither party shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are limited to acts of God or of a public enemy, government action, outbreak of disease, explosion, fires, unusually severe weather, or other events(s) outside of the reasonable control of a party. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other within a reasonable time of the existence and nature of the delay.

SECTION 5. GENERAL PROVISIONS

5.01 If during the Contract Term any new or increased tax, assessment, or fee is imposed on the amounts payable to, or by, Delta Dental under this Contract or any immediately preceding contract between Delta Dental and the Contractholder, the amount stated in Appendix A will be increased by the amount of any such new or increased tax, assessment, or fee. Delta Dental will therefore provide written notice of such circumstance to Contractholder, and the Contract shall thereby be modified on the date set forth in the notice.

5.02 The parties agree that all questions regarding interpretation or enforcement of the Contract shall be governed by the laws of the State of California, where the Contract was entered into and is to be performed. Any provision of the Contract which, on its Effective Date, is in conflict with statutes of said state is hereby amended to conform to minimum requirements of such statutes.

5.03 Delta Dental is a member of the Delta Dental of California Holding Company System (the "Enterprise") under common management and administration. It is expected that some services under this Contract (i.e., claims processing or call center support) may be performed by Enterprise companies which operate under strict confidentiality and/or business associate agreements and for which Delta Dental remains responsible.

5.04 Delta Dental will not be responsible or liable for any incorrect, obsolete or unreadable data or information supplied to Delta Dental including, but not limited to, eligibility and enrollment information.

5.05 All formal notices required under the Contract must be in writing and sent by email, first-class United States Mail, overnight delivery service or personal delivery. Notice by first class United States Mail shall be effective forty-eight (48) hours after mailing.

Notice to Delta Dental shall be to:

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105
Website Address: deltadentalins.com

Notice to Contractholder shall be to: Snowflake Inc.
125 Constitution Drive
Menlo Park, CA 94025-1118
Website Address: www.snowflake.net

- 5.06 Both parties to the Contract agree to permit and encourage the professional relationship between Provider and patient to be maintained without interference.
- 5.07 The Contract may not be amended except where expressly stated herein or in writing by mutual consent of Delta Dental and Contractholder.
- 5.08 If any portion of the Contract or any amendment thereto shall be determined by a court or other competent authority to be illegal, void, or unenforceable, such determination shall not abrogate the Contract or any portion thereof other than such portion determined to be illegal, void, or unenforceable, and all other portions of the Contract shall remain in full force and effect.
- 5.09 Contractholder shall comply in all respects with applicable federal, state, and local laws and regulations relating to administrative simplification, security, and privacy of individually identifiable Enrollee information. The Contractholder agrees that this Contract may be amended as necessary to comply with federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 or to comply with any other enacted administrative simplifications, security, or privacy laws or regulations.
- 5.10 Absent fraud, each statement made by the Contractholder or Enrollee is considered to be a representation and not a warranty.
- 5.11 The parties agree to maintain confidential information using the same degree of care (which will be no less than reasonable care) as each uses to protect its own confidential information of a similar nature and to use confidential information only for specified purposes. Confidential information includes any information which the owner deems confidential, whether marked as confidential or otherwise clearly identifiable as confidential and includes information not known by the public or by parties which are competitive with or otherwise in an industry, trade or business similar to the owner of the confidential information. Subject to the terms of the Business Associate Agreement agreed hereto, the recipient of confidential information will notify the owner of any unauthorized disclosure or breach of confidentiality as soon as possible after discovery and without unreasonable delay.

SECTION 6. TERMINATION AND RENEWAL

- 6.01 The Term of the Contract shall be for the period set forth in Appendix A.

Delta Dental will notify the Contractholder in writing within 120 days prior to the end of each Contract Term of the renewal information.

- 6.02 The Contract may be terminated only for the following:

- a) By Delta Dental, upon Contractholder's failure (i) to furnish Delta Dental with a list of all Primary Enrollees and Dependent Enrollees as required under Section 3.01; (ii) to permit the inspection of records as called for under Section 3.02; or (iii) to pay all amounts due, in the amount and manner required by Section 3 and Appendix A.
- b) By either Contractholder or Delta Dental, upon expiration of a Contract Term, with no less than sixty (60) days' written notice.
- c) By Delta Dental, in the event that the number of Primary Enrollees reported by Contractholder to Delta Dental shall be less than the minimum number of Primary Enrollees (shown in Appendix A) in each of three (3) consecutive months, but only upon written notice, given not more than 15 days after receipt of the list of Primary Enrollees which indicates that such grounds for termination exist, effective as of the last day of the month in which notice of termination is given.
- d) By Delta Dental, in the event that the bank account for claim payment remains underfunded as a result of insufficient funds for more than fifteen (15) days. The Contract shall terminate as of the last day of the month after the fifteen (15) days under funding has occurred.

- e) By Contractholder or Delta Dental, upon thirty (30) days' written notice from the terminating party, for reasons which include, but are not limited to, misuse of funds, fraud, lack of compliance with applicable rules, laws, regulations, and ordinances, and failure to perform in a timely manner any provision of this Contract.

6.03 In the event of termination by Delta Dental, all Benefits shall terminate and Delta Dental shall be released from all further obligations of the Contract other than administration of the claims run-out period identified below, effective on the last day of the month for which written notice of termination is given. Contractholder shall remain liable for claims incurred, paid or otherwise discharged during the term of the Contract and during the twelve (12) month claims run-out period.

6.04 In the event of termination, Delta Dental shall be paid its compensation for services performed prior to the termination date, including all reimbursable expenses then due or incurred to the date of termination, within thirty (30) days following the date of termination. Delta Dental and the Contractholder understand and agree that at the expiration of this Contract or any extension thereto, the Contractholder shall not otherwise be further obligated to Delta Dental except for claims and other payments due to providers incurred, paid, or otherwise discharged during the term of the Contract and during the twelve (12) month claims run-out period.

SECTION 7. ATTACHMENTS

The following documents are attached to this Contract and made a part hereof:

Appendix A Administrative Contract Variables

Appendix B Employee Benefit Booklet

SECTION 8. SIGNATURES

The terms of this Contract are agreed to by:

DELTA DENTAL OF CALIFORNIA

SNOWFLAKE INC.



Name of Officer: Michael G. Hankinson, Esq.

Name of Officer: _____

Title: EVP, Chief Legal Officer

Title: _____

Date: November 19, 2025

Date: _____

APPENDIX A

ADMINISTRATIVE CONTRACT VARIABLES

- A. Contract Number: 20239
- B. The administrative services performed by Delta Dental under this Contract shall be effective commencing on January 1, 2026.
- C. The Contract Term shall be for the period commencing on January 1, 2026 and concluding on December 31, 2026.
- D. The monthly administrative charge is based on a minimum of 4,256 covered employees and the composition of the Contractholder's group at the beginning of each Contract Term. Delta Dental may propose a choice of changes in administrative charges for a 15 percent change in composition during the Contract Term, such as an increase or decrease in enrollment, change in location, change in job classifications, change in mix of active versus retiree enrollment or other similar change in the Contractholder's group composition that lasts three (3) months in a row or longer and results in an increase in cost per person of the Contractholder's group. Within 31 days of receipt of the proposed change(s), Contractholder will select one of the choices by written notice to Delta Dental. If Contractholder fails to do so, Delta Dental may select one of the choices by written notice to Contractholder. This Contract will be modified for all dental services predetermined and incurred after notice.
- E. Delta Dental on a monthly basis will reconcile and bill for the administration of the Plan. Contractholder shall furnish to Delta Dental monthly payments of \$3.60 for each Primary Enrollee as compensation for administering the program. Any payment received after 90 days of the due date shall be subject to interest equal to one percentage point above the then current three month U.S. Treasury Bill rate.

The cost of claims submitted by Premier Providers as shown on the weekly summary of claims paid will be calculated using the lesser of the submitted charge or the 90th percentile. Contractholder agrees that any difference between the invoiced amount of claims paid and the contracted fee paid to Premier Providers will be retained or absorbed by Delta Dental as the administrative charge.
- F. Delta Dental may change the amounts charge whenever the Contract is amended or whenever the Contractholder requests a change in Benefits or eligibility or when applicable under 5.01. Any change in amounts due shall not be effective during a Contract Term unless Contractholder and Delta Dental agree in writing (except as provided in D and E above or when applicable under 5.01).
- G. The minimum number of Primary Enrollees for termination purposes is less than 10 or a reduction of 30% or more over three (3) consecutive months.

APPENDIX B

EMPLOYEE BENEFIT BOOKLET

Snowflake Inc.



deltadentalins.com

Group No: 20239

Effective Date: January 1, 2026

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INTRODUCTION

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

This Employee Benefit Booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by Delta Dental of California ("Delta Dental") and cannot modify the Contract in any way.

Using This Employee Benefit Booklet

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

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

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

Contact Us

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

You can access our automated information line at 888-335-8227 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

*Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105*

DEFINITIONS

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

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

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

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

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

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

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

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

Days: any mention of “days” in this Employee Benefit Booklet shall be calendar days unless defined otherwise.

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

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

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

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

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

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: the original date the Contract starts. This date is given on this booklet’s cover.

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

Eligible Employee: any employee as eligible for Benefits.

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

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

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

Maximum: is the maximum dollar amount (“Maximum Amount” or “Maximum”) Delta Dental will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. Delta Dental

will pay the Maximum Amount(s), if applicable, shown in Attachment A for Benefits under the Contract.

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

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

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

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

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

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

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

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

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

Qualifying Status Change: a change in:

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

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

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

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

COST OF COVERAGE

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

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

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

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported. You are eligible to enroll if you meet the eligibility requirements defined by the Contractholder.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

- Dependents are the Primary Enrollee's Spouse and dependent children from birth to age 26.
- Children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a Dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status.
- An overage dependent child may be eligible if:
 - (1) he or she is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
 - (2) he or she is chiefly dependent on the eligible employee for support; and
 - (3) proof of dependent child's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the eligible employee for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.

Dependents serving active military duty are not eligible, as they are typically covered under health and dental coverage provided by the military while they are on active duty.

Enrollment Requirements

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

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees for coverage.
- You must pay the cost of coverage in the manner elected by the Contractholder and approved by us. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If you pay the cost of coverage for your Dependent Enrollees, you must pay in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.
- If both you and your Spouse are eligible persons, one may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

Loss of Eligibility

Your coverage ends on the earlier of (1) the last day of the month you stop working for the Contractholder, (2) are no longer an Eligible Employee of the Contractholder or (3) immediately when the Contract ends. Your Spouse loses coverage when your coverage ends or when dependent status is lost. Your dependent children lose coverage when your coverage ends or the last day of the month when dependent status is lost.

Continuation of Benefits

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

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Benefits for you and your Dependent Enrollees will resume as follows:

- if coverage is reactivated in the same Calendar Year, Deductibles and maximums will resume as if you were never gone; or
- if coverage is reactivated in a different Calendar Year, new Deductibles and maximums will apply.

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

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

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

If you are rehired within the same Calendar Year, Deductibles and maximums will resume as if you were never gone.

Continued Coverage under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins, or;
- the date you fail to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the cost of coverage for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

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

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

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

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

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

Enrollee Coinsurance

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

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

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

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in Attachment A. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered Benefits will count toward the Deductible.

Maximum Amount

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

Pre-Treatment Estimate

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

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

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

Coordination of Benefits

We coordinate the Benefits under the Contract with an Enrollee's benefits under any other group or pre-paid plan or Benefit plan designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce Benefits. If this plan is the "secondary" plan, we may reduce Benefits otherwise payable under the Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

- How do we determine which plan is the "primary" program?
 - (1) The plan covering you as an employee is primary over a plan covering you as a dependent.
 - (2) The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a) secondary to the plan covering the insured person as a dependent and
 - b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
 - (3) Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:

- a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
 - b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.
- (5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).
- (6) The Benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
- a) First, the Benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
 - b) Second, the Benefits under the continuation coverage.
- If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (8) If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the plan which covered you for the shorter term.
- (9) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

Free Choice of Provider

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

Locating a PPO Provider

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

Choosing a PPO Provider

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

Choosing a Premier Provider

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

Choosing a Non-Delta Dental Provider

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

Additional Obligations of PPO and Premier Providers

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

How to Submit a Claim

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

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

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

Payment Guidelines

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

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

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

Provider Relationships

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

CLAIMS AND APPEALS

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. For post-service claims, if you have provided all of the information needed to process the claim, we will notify you within thirty (30) days of receipt of the claim, unless an extension of up to fifteen (15) days is necessary due to matters beyond the control of the Plan. If an extension is necessary, we will notify you of the circumstances requiring the extension before the end of the thirty (30) day period and provide the date by which we expect to render a decision. If the extension is necessary because you have not submitted the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information.

For pre-service claims involving urgent care, we will notify you of the Plan's benefit determination (whether or not adverse) as soon as possible, taking into account the dental exigencies, but no more than seventy-two (72) hours after receipt of the pre-service claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. Notice of a decision on an urgent care pre-service claim may be provided orally within this time frame, provided that written or electronic notice is provided no less than three (3) days after the oral notification. If you fail to provide sufficient information for us to decide an urgent care pre-service claim, we will notify you of the specific information necessary to complete the claim as soon as possible, but no later than twenty-four (24) hours after receipt of the pre-service claim. We will allow additional time for you to provide the specified information. The additional time will be a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours. In such cases, we will notify you of our benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (i) the receipt of the specified additional information, or (ii) the expiration of the period afforded you to provide the specified additional information.

For purposes of the Plan, a "claim involving urgent care" is any claim for care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of a licensed clinical professional with knowledge of the claimant's dental condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a "claim involving urgent care" is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a licensed clinical professional with knowledge of the claimant's dental condition determines is a "claim involving urgent care" shall be treated as a "claim involving urgent care" for purposes of the Plan's claims and appeals provisions.

If we have approved an ongoing course of treatment to be provided over a period of time or number of treatments, then the following applies:

- Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. We will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to

appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

- Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and we will notify you of the benefit determination (whether adverse or not) within twenty-four (24) hours after we receive the claim, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

The Plan does not currently require prior authorization to receive benefits, so you are not currently required to follow procedures for pre-service claims.

Notice of Claim Denial

If your claim is denied, we will notify you in writing and provide the following:

- The specific reason(s) for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such material or information is necessary;
- An explanation of the Plan's review procedures and the time limits applicable to such procedures;
- Your right to bring a civil action under ERISA Section 502(a) after exhausting all claims and appeals processes;
- If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a notice of where and how you can obtain a copy, free of charge;
- If your claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;
- In the case of a denial concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and
- A statement that additional information regarding voluntary alternative dispute resolution options, such as mediation, may be obtained by contacting your local U.S. Department of Labor Office.

If the denial concerns a claim involving urgent care, the information described above may be provided to the claimant orally within the applicable time period described in "Timing of Claim Decision," provided that a written or electronic notification is furnished no later than three (3) days after the oral notification.

Timing of Appeal

You have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You and your Provider will have the opportunity to submit written comments, documents, records, and other information relating to the claim and may ask Delta Dental to examine any additional information provided that may support the appeal or grievance. Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits (other than legally or medically privileged documents), a copy of any internal rule, guideline, protocol and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claims.

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

Delta Dental of California
Customer Service Department
P.O. Box 997100
Sacramento, CA 95899
Phone Number: 888-335-8227

Review of Appeal

For appeals of post-service claims, we will send you a written acknowledgment of receipt within five (5) days upon our receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered in the initial claim determination. The review will be conducted for us by an appropriate person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The review does not afford deference to the initial adverse benefit determination.

If your appeal is based in whole or in part on a clinical judgment, including determinations with regard to whether a particular treatment, drug, or other item is an experimental, investigational, or unproven service or not medically necessary or appropriate, the appropriate named person will consult with an appropriately trained and experienced dentist, who will not be the individual who was consulted in connection with the initial claim determination that is the subject of the appeal nor the subordinate of such individual. Upon request, we will provide for the identification of any licensed clinical or vocational experts whose advice was obtained in connection with the denial of your claim, without regard to whether the advice was relied upon in making the claim determination.

In the case of a claim involving urgent care, (i) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (ii) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Notice of Appeal Decision

For appeals of post-service claims, we will send the Enrollee a written decision within sixty (60) days after receipt of the Enrollee's appeal or grievance. If your appeal is denied, the notice will include the following:

- The specific reason(s) for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based;
- Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures;
- Your right to bring a civil action under ERISA Section 502(a) after completion of all required levels of review;
- If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a notice of where and how you can obtain a copy free of charge upon request;
- If your claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

For a claim involving urgent care, we will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of your request for review of an adverse benefit determination.

If the Enrollee believes they need further review of their appeal or grievance, they may contact their state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action

under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Non-Discrimination

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:

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

If you need these services, contact Delta Dental's Customer Service Center at 800-471-0287.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

Delta Dental
P.O. Box 997100
Sacramento, CA 95899
Telephone Number: 800-471-0287
Website Address: deltadentalins.com

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

Clinical Examination

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

Notice of Claim Form

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

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been

complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

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

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

Time of Payment

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

To Whom Benefits Are Paid

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

Aside the foregoing, neither you, the Primary Enrollee, nor a Dependent Enrollee, nor your dependents, nor any beneficiaries may assign, sell, transfer, pledge, charge, encumber, or allow any Benefits under this group dental program without the written consent of Delta Dental. Any assignment by you will be void. To the extent allowed by law, Delta Dental will not accept an assignment to a Non-Delta Dental Provider or facility for any reason, including but not limited to, an assignment of the right to receive payments. Any payments made by Delta Dental to a Non-Delta Dental Provider or facility does not create a waiver of this section nor grant a Non-Delta Dental Provider rights under the Contract or ERISA.

Misstatements on Application: Effect

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

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same coverage rate. If any misstatement would materially affect the rates, we reserve the right to adjust the coverage rate to reflect your actual circumstances at enrollment.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.

Attachment A

Description of Dental Benefits, Deductibles, Maximums and Contract Benefit Levels

Deductible and maximum amounts will be determined on a Calendar Year basis per Enrollee unless otherwise stated and are subject to *Attachment B - Limitations and Exclusions*.

Description of Dental Benefits	
Dental Benefit	Dental Benefit Description
Benefit Category	
Exams	evaluation to assess oral health
Diagnostic and Preventive	
X-Rays	radiographic imaging services to aid diagnosis
Diagnostic and Preventive	
Prophylaxis	services to remove plaque, tartar and stains from the tooth surface
Diagnostic and Preventive	
Fluoride	topical application of fluoride in the dental office
Diagnostic and Preventive	
Space Maintainers	oral appliance made to “maintain” the space created by the loss of a tooth
Diagnostic and Preventive	
Sealants	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay
Diagnostic and Preventive	
Minor Restorative	amalgam (silver filling) and resin-based composite (tooth-colored filling) and prefabricated crowns for treatment of decay, failing restorations or fractures
Basic	
Endodontics	treatment of diseases and injuries of the tooth pulp
Basic	
Periodontics; Surgical	surgical treatment of gums and bones supporting teeth
Basic	
Periodontics; Non-Surgical	non-surgical treatment of gums and bones supporting teeth
Basic	
Periodontal Maintenance	a cleaning performed to maintain periodontal health after periodontal treatment
Basic	
Denture Repair/Rebase/Reline	repair to partial or complete dentures, including rebase procedures and relining
Major	
Extractions	removal of teeth
Basic	
Surgical Extractions	removal of teeth by opening the gums and removing bone
Basic	
Other Oral Surgery	oral surgery services with the exception of surgical and non-surgical extractions
Basic	
Palliative Treatment	treatment to relieve pain
Basic	
IV Sedation & General Anesthesia	when administered by a Dentist for Oral Surgery or selected endodontic and periodontal surgical procedures
Basic	

Consultation	opinion or advice requested by a Dentist
Basic	
Major Restorative	treatment of decay and fracture when teeth cannot be restored with amalgam (silver filling) or resin-based composites (tooth-colored filling)
Major	
Prosthodontics; Removable	procedures for construction, modification and repair of partial or complete dentures
Major	
Prosthodontics; Fixed	procedures for construction, modification and repair of fixed bridges
Major	
Implants	procedures for the surgical placement and removal of endosteal, eposteal and transosteal implants and for implant supported prosthetics, including implant connecting bars, implant repairs and recementation. Implants are defined as prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain implant supported dental prosthesis
Major	
Orthodontic	procedures using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function
Orthodontic	
Cone Beam CT	x-ray technique that captures multiple images of the head and neck from a variety of angles
Major	

Additional Benefits During Pregnancy

We will pay for additional Benefits to help improve oral health during pregnancy. The additional Benefits include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided when the claim is submitted.

Deductibles

Annual Deductible	\$50 per Enrollee \$150 per family
Deductibles waived for	Diagnostic & Preventive and Orthodontic Benefits

Maximums

Annual Maximum	\$2,000
Annual Maximum waived for	Diagnostic & Preventive Benefits
Lifetime Orthodontic Maximum	\$2,000 per Enrollee

Contract Benefit Levels

Our reimbursement to Dentists is based on PPO Maximum Contract Allowance for PPO Dentists, Premier Maximum Contract Allowance for Premier Dentists and Program Allowance for Non-Delta Dental Dentists.

We will pay the Contract Benefit Level for the following Benefits.

You are responsible for paying the balance not paid by Us which is referred to as Coinsurance. The amount of Coinsurance will depend on the Benefit category and the Dentist providing the service.

Dental Benefit Category	PPO and Premier Dentists	Non-Delta Dental Dentists
Diagnostic and Preventive	100%	100%
Basic	90%	90%
Major	60%	60%
Orthodontic	50%	50%

Attachment B

Limitations and Exclusions

Limitations

- 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:

- o a composite restoration instead of an amalgam restoration on posterior teeth;
 - o a crown where a filling would restore the tooth;
 - o an inlay/onlay instead of an amalgam restoration;
 - o 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
 - o an overdenture instead of a denture.
- Exam and cleaning limitations:
 - o 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-full mouth, periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year.
 - o Full mouth debridement is not allowed when performed by the same Dentist/Dentist office on the same day as evaluation procedures.
 - o A full mouth debridement is allowed once in a lifetime when You have no history of prophylaxis, scaling and root planing, periodontal surgery or periodontal maintenance procedures within three (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
 - o Note that periodontal maintenance, Procedure Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit and that routine cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
 - o Caries risk assessments are allowed once in 12 months.
 - Image limitations:
 - o We will limit the total reimbursable amount to the Dentist's Submitted Fee for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Submitted Fee for a comprehensive intraoral series.
 - o If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Dentist's Submitted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be Your responsibility. Panoramic images are not considered part of a comprehensive intraoral series.
 - o Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
 - o Bitewing images are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
 - o Bitewing images of any type are included in the fee of a comprehensive series when taken within six (6) months of the comprehensive images.
 - o Bitewing images are limited to two (2) images for Dependent Enrollee children under age 10.
 - o Image capture procedures are not separately billable services.
 - 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/Dentist office than the Dentist/Dentist office who provided the cone beam capture only services.
 - Topical application of fluoride solutions is limited to age 19 and no more than twice in a Calendar Year.
 - Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

- Space maintainer limitations:
 - Space maintainers are limited to the initial appliance and are a Benefit for Dependent Enrollee children to age 14. A distal shoe space maintainer-fixed-unilateral is limited to Dependent Enrollee children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
 - Recementation of space maintainer is limited to once per lifetime.
 - The removal of a fixed space maintainer is included in the fee. An exception is made if the removal is performed by a different Dentist/Dentist office.
- Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- Cephalometric images, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered Benefit. 3D images are not a covered Benefit.
- Sealants are limited as follows:
 - 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.
 - repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.
- Specialist Consultations are limited to once per lifetime per Dentist and count toward the oral exam frequency. Screenings or assessments reported individually when covered are limited to only one (1) in a 12-month period and included if reported with any other examination on the same date of service and Dentist office.
- We will not cover replacement of an amalgam or resin-based composite restoration (filling) or prefabricated crowns within 24 months of treatment if the service is provided by the same Dentist/Dentist office. Replacement restorations within 24 months are included in the fee for the original restoration.
- Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- The removal of an indirect restoration is a part of a subsequent restorative procedure.
- Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth for Dependent Enrollee children to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.
- Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Dentist/Dentist office within 24 months is considered part of the original procedure.
- Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit for Dependent Enrollees to age 19.
- Retreatment of apical surgery by the same Dentist/Dentist office within 24 months is considered part of the original procedure.
- Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select Diagnostic procedures.
- Periodontal limitations:
 - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be covered on the same date of service.
 - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Dentist/Dentist office.

- o Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
- o Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
- o Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Dentist office.
- o When implant procedures are a covered Benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Service and are limited to once in a 24-month period.
- Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.
- The following Oral Surgery procedure is limited for Dependent Enrollees to age 19 (or Orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.
- The following Oral Surgery procedures are limited for Dependent Enrollees to age 19 (or Orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
- Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or the frenum is contributing to the presence of a large diastema(s).
- Crowns and inlays/onlays are limited for Dependent Enrollee children to age 12 and older and are covered not more often than once in any 60-month period except when We determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- Core buildup, including any pins, are covered not more than once in any 60-month period.
- Post and core services are covered not more than once in any 60-month period.
- Crown repairs are covered not more than twice in any 60-month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.
- Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than twice in any 60-month period.
- Prosthodontic appliances, implants and/or implant supported prosthetics that were provided by Us will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided by Us will be made if We determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for implant site per lifetime whether provided under Our plan or any other dental care plan.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Dentist/Dentist office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Dentist/Dentist office.

- We limit payment for dentures to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
 - Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
 - Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.

Immediate dentures and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.

- Tissue conditioning is limited to two (2) per arch in a 12-month period. Tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
- Recementation of fixed partial dentures is limited to once in a lifetime.
- Orthodontic limitations:
 - Benefits for Orthodontic Services will be provided in periodic payments based on Your continuing eligibility.
 - Benefits are not paid to repair or replace any Orthodontic appliance received.
 - Benefits are not paid for Orthodontic retreatment procedures.
 - Orthodontic treatment must be provided by a licensed Dentist.
 - The removal of fixed Orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.
 - Limited orthodontic treatment (any dentition) and comprehensive Orthodontic treatment (any dentition) are part of comprehensive Orthodontic treatment with orthognathic surgery.
- All Orthodontic services, including direct to consumer Orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for Benefits that are not provided by a Dentist are not eligible for reimbursement.
- The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.
- When done in conjunction with the removal of an impacted tooth, complete bony, with unusual surgical complications, nerve dissection is part of that extraction procedure. Otherwise, nerve dissection is not a Benefit.

Exclusions

We do not pay Benefits for:

- Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Maxillofacial prosthetics.
- Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for Dependent Enrollee 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.
- 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 Dependent Enrollee children for medically diagnosed congenital defects or birth abnormalities.

- 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.
- Any Single Procedure provided prior to the date the Enrollee became eligible for Benefits under this Plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- Charges for anesthesia, other than General Anesthesia and IV Sedation in connection with Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- Extra oral grafts (grafts of tissues obtained from extraoral sites of the Enrollee's own body to their oral tissues).
- Laboratory processed crowns for Dependent Enrollee children under age 12.
- Fixed bridges and removable partials for Dependent Enrollee children under age 16.
- Interim implants, endodontic endosseous implant and extraoral implants.
- Indirectly fabricated resin-based inlays/onlays.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening or tobacco counseling.
- 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.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- Deductibles, amounts over plan maximums and/or any service not covered under this Plan.
- Services covered but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefits section.
- Services for any disturbance of TMJ or associated musculature, nerves and other tissues except as provided under the TMJ Benefit section.
- Missed and/or cancelled appointments.
- Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

- The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- Dental case management motivational interviewing and patient education to improve oral health literacy.
- Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- Diabetes testing.
- Corticotomy (specialized Oral Surgery procedure associated with Orthodontics).
- Antigen or antibody testing.
- Counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use.
- Services or supplies for sleep apnea.
- Cone beam image capture only is not a covered Benefit.
- Administration of dermal fillers.
- Administration of neuromodulators.

Attachment C Wellness Benefits

Wellness Benefits are available to help improve the oral health of Enrollees with certain Qualifying Medical Conditions.

Qualifying Medical Conditions

Enrollees with one or more of the following Qualifying Medical Conditions will receive Wellness Benefits: cardiovascular (heart) disease; diabetes; cerebrovascular disease (stroke); HIV/AIDS; rheumatoid arthritis; chronic kidney disease; Sjogren's syndrome; lupus; Parkinson's disease; amyotrophic lateral sclerosis; Huntington's disease; opioid misuse and addiction; joint replacement; and cancer.

Wellness Benefits

The information in the table below replaces the coverage for routine cleanings, periodontal maintenance and periodontal scaling and root planing described in Attachments A and B.

Service	PPO and Premier Providers' Contract Benefit Level	Non-Delta Dental Providers' Contract Benefit Level	Limitations
Routine Cleaning & Periodontal Maintenance¹	100%	100%	any combination of four (4) each Calendar Year Contract Year
Periodontal Scaling & Root Planing	100%	100%	once every Calendar Year per quadrant with no more than two (2) quadrants covered on the same date of service.

¹If an Enrollee is eligible for a pregnancy benefit and is also eligible for the Wellness Benefit, then Wellness Benefits replace the additional pregnancy benefits described in Attachment A, except such Enrollees will be entitled to one additional oral exam each Calendar Year while pregnant provided that written confirmation of the pregnancy is submitted.

All other Benefits, Limitations and Exclusions remain unchanged. Wellness Benefits are subject to applicable Deductibles and Maximums.

Signing up for Wellness Benefits

1. Go to deltadentalins.com.
2. Log in to your Online Services account. (If you don't have one, click Register.)
3. Click on the Optional Benefits tab in the left column.
4. Click on Opt In next to the name of the person you want to enroll. You can enroll yourself or a dependent child.
5. Complete and submit the form.