

EXHIBIT C

Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703
800-422-4234

DELTACARE® USA GROUP DENTAL SERVICE CONTRACT

Introduction

Contractholder has applied for a group dental service contract with Delta Dental of California ("Company"), on behalf of itself, and its affiliated companies, on the following terms:

- Contractholder will pay Us or Our Third Party Administrator ("Administrator"), the Premiums as shown on the Group Information section.
- Upon acceptance of the Contractholder's signed application and in consideration of payment of the first month's Premium, the term of this Contract will begin at 12:01 a.m. Standard Time on the Effective Date shown on the Group Information section and end on the Contract Term date at 12:00 a.m. Standard Time.

This Contract as issued describes the terms and conditions of coverage. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the provisions carefully.

Persons with special health care needs should read the section entitled "Special Health Care Needs" in the EOC. Pursuant to the California Health and Safety Code, the EOC provides Enrollees with information regarding the societal benefits of organ donation and the method whereby an Enrollee may elect to be an organ or tissue donor. Enrollees may also obtain information about Benefits by calling Customer Service at 800-422-4234.

In consideration of payment of all Premium shown in the Group Information section, We agree to provide the Benefits described in the Schedules and any riders or attachments to the Evidence of Coverage ("EOC") subject to the Contract terms. The EOC and Schedules are attached and incorporated herein by reference. The parties will fulfill the obligations stated herein.

Terms such as "We," "Us" and "Our" refers to the Company or Our third party administrator. Additional terms have specific meanings and are described in the Definitions section of this Contract and the EOC.

This Contract is issued and delivered in California, and is governed by its laws.

San Bernardino County

Executed this 26th day of July, 2022

for the Contractholder at: San Bernardino, California
City and State

By: Curt Hagman, Chairman, Board of Supervisors

Signature: _____

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD

Lynna Mongelli
Clerk of the Board of Supervisors
of the San Bernardino County

By: _____

Deputy

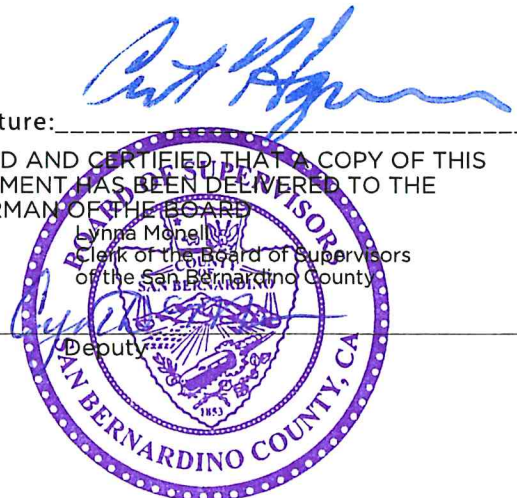
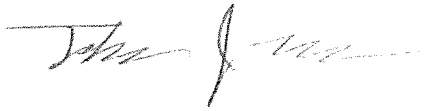


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**DELTA DENTAL OF CALIFORNIA:
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90702**

A handwritten signature in black ink, appearing to read "Thomas J. Leibowitz".

**Thomas J. Leibowitz, FSA, MAAA
Group Vice President and Chief Actuary**

A handwritten signature in black ink, appearing to read "Mohammadreza Navid".

**Mohammadreza Navid
Group Vice President, Sales**

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Section 1. Definitions

Terms with capital letters appearing in this Contract will have the meaning given to them in the attached Evidence of Coverage ("EOC"). In addition, the following terms will have these meanings:

Contract: This agreement between Us and the Contractholder including the EOC and any attachments. This Contract constitutes the entire agreement between the parties.

Contract Term: The period during which this Contract is in effect, as shown in the Group Information section.

Contractholder: The entity that enters in to and executes this Contract to obtain dental benefits.

Effective Date: The date this Contract begins, as shown in the Group Information section.

Grace Period: A period of at least 60 consecutive days beginning the day the Notice of Start of Grace Period is dated.

Premium: The amount the Contractholder or an Enrollee, if applicable must pay for coverage and stated in the Group Information section.

Section 2. Duties of the Company

- 2.01 We or Our third party administrator or other authorized representative will perform administrative functions necessary to ensure the provision of benefits for the Contractholder and its Enrollees. Such functions may include, but are not limited to, enrollment, premium billing, claims processing, providing a dental network, responding to inquiries and complaints that may arise under this Contract, and maintaining records.
- 2.02 In the absence of an amendment mutually agreed upon between the parties, no changes to this Contract will be made during a Contract Term.

Section 3. Duties of Contractholder

3.01 Reporting Enrollment

We will process enrollment as reported to Us by the Contractholder. On or before the Effective Date, the Contractholder will furnish Us, in writing or in an electronic format as agreed, a listing of eligible Primary Enrollees, and Dependent Enrollees, if applicable. Electronic format may be made by file transmissions, Our web tool or a combination of the two.

Thereafter, the Contractholder must furnish in an agreed format, a listing before the 10th day of each month indicating specific additions, changes or terminations made during the prior month. Otherwise, an Enrollee remains enrolled until We receive notice of the termination. If the Primary Enrollee loses coverage or makes any change that affects an Enrollee's eligibility, We must be promptly notified of such change.

The Contractholder will notify Us of, in writing or in an electronic format, any requests for Premium adjustments for Enrollees who should have been terminated but for which no notice was provided to Us. Adjustments will be applied retroactively up to the immediately preceding 3 months plus the current billing month. We will not make any payment for services provided to an Enrollee who is not reported as an Enrollee when the service is provided.

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We will not pay services provided to an Enrollee if Premiums are not paid for the month in which the dental services are rendered, except as stated in the grace period provision. We will not be obligated to recover claims paid to a Dentist as a result of retroactive eligibility adjustments. The Contractholder agrees to reimburse Us for any erroneous claim payments as a result of incorrect eligibility reporting by the Contractholder.

3.02 Audit

Upon Our reasonable written notice, the Contractholder will permit Us to audit books and records to confirm compliance with these provisions.

3.03 Premiums

This Contract will be effective when We receive the first month's Premium. Subsequent Premiums are due the first day of each month.

In accordance with the Group Information section, Contractholder agrees to:

Collect Premiums by means of payroll deductions for Primary Enrollees and Dependent Enrollees voluntarily enrolled for Benefits.

Contractholder will remit one check each period as required.

Should an Enrollee voluntarily cancel enrollment and subsequently desire to re-enroll, all Premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before the Enrollee will be reenrolled.

For enrollment additions, Contractholder will remit a full month's Premium for Enrollees whose coverage is effective on the first through the fifteenth calendar day of a month. Premiums are not due to Us for Enrollees who are enrolled on the sixteenth through the last day of a month.

For enrollment terminations, Contractholder will remit a full month's Premium for Enrollees whose coverage is terminated on the sixteenth through the last calendar day of a respective month. Premiums are not due to Us for Enrollees whose enrollment is terminated on the first through the fifteenth day of a month.

In the event enrollment is cancelled by Us, We will return the pro-rata portion of the Premium which corresponds to any unexpired period for which payment had been received, less any amounts due on claims, if any, less any amounts owed to Us. This provision will not apply in instances of Enrollee fraud or deception in obtaining Benefits for themselves or others.

3.04 If this Contract is terminated before the end of a Contract Term, Contractholder will pay additional charges as provided under this Contract.

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3.05 Any payment received after 90 days of the due date will be subject to interest charges at an annualized rate equal to one percentage point above the then current 3 month U.S. Treasury Bill rate, which interest will commence accruing as of the first day following the end of the grace period.

3.06 Certificates and Notices

We will furnish the Contract, EOC, Schedules and any attachments to the Contractholder which will set forth the essential features of the dental coverage.

Contractholder will provide Primary Enrollee an Evidence of Coverage ("EOC") supplied by the Us.

Contractholder will distribute any Enrollee notices from Us which may affect their rights under this Contract.

3.07 No change in Benefits will become effective during a Contract Term unless Contractholder and Us agree in writing and the Contractholder has been provided at least 30 days advanced written notice at the most current address on record with Us.

Section 4. Termination, and Grievance Process for Cancellation, Rescission, or Nonrenewal

4.01 We may cancel the Contract only:

- upon 30 days' written notice if Contractholder fails to pay Premiums, in the amount and manner required: The Enrollee and Contractholder are financially responsible for any and all premiums and any copayment, coinsurance, or deductible amounts obligated under the plan contract, including those incurred for services received during the grace period.
- upon 60 days' written notice if Contractholder fails to comply with material provisions relating to employer contribution or group participation rates by the Contractholder or employer of the Contract; or
- Upon 60 days' written notice if We demonstrate fraud or an intentional misrepresentation of material fact.

If this Contract is terminated for any cause, We will not be required to provide Preauthorization if this Contract is terminated for any cause nor will We be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while this Contract or if there is a cancellation grievance pending for reasons other than nonpayment of premium submitted prior to the effective date of the Contract's cancellation, rescission or nonrenewal.

4.02 Cancellation of Contract due to Non-payment of Premium

We may cancel the Contract after written notice if premiums, or a portion of premiums, are not paid by the due date after being billed for the charge. We will provide a Notice of the Start of Grace Period to the Contractholder stating a payment delinquency has triggered a Grace Period of 60 days starting the day the Notice of Start of Grace Period is dated. The Contractholder will promptly send or make available a copy of this to all Enrollees. Coverage will remain in effect during the Grace Period.

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The Contractholder will be financially for any and all premiums incurred during the Grace Period.

A Notice of End of Coverage will be provided to the Contractholder for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes the following statement: "To learn about new coverage or whether your coverage can be reinstated, contact Us at deltadentalins.com." The Contractholder will promptly send or make available a copy of this notice to all Enrollees. If Enrollees lose coverage, they may be financially responsible for the payment of claims incurred.

4.03 Cancellation of Contract for other than Non-Payment of Premium

For cancellations, rescission and non-renewals for other than for nonpayment of premium, We will provide the Contractholder with a Notice of Cancellation, Rescission or Nonrenewal. The Contractholder will promptly send or make available a copy of this notice to Enrollees. A Notice of End of Coverage will be provided to the Contractholder for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes:

- The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact Us at deltadentalins.com."
- Notice as to the availability of the right to request completion of covered services.

If the Contract is terminated for any cause, We are not required to Pre-Treatment Estimates beyond the termination date or to pay for services provided after the termination date, except for services begun while the Contract was in effect or if You have a cancellation grievance pending for reasons other than nonpayment of premium submitted prior to the effective date of Your cancellation, renewal or rescission.

4.04 RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION OR CONTRACT

Enrollees, Primary Enrollees and Contractholders who believe their coverage has been, or will be, improperly cancelled, rescinded or not renewed have at least 180 days from the date of the notice alleged to be improper to submit a grievance to Us and/or the Department of Managed Health Care ("DMHC").

For grievances submitted prior to the effective date of the cancellation, rescission or non-renewal, for reasons other than nonpayment of premium, We will continue to provide coverage while the grievance is pending with Us or the DMHC. During the period of continued coverage, the Primary Enrollee or the Contractholder is responsible for paying premiums and any and all copayments, coinsurance, or deductible amounts as required.

Reinstatement of Coverage

If it is determined the cancellation, rescission or nonrenewal, including a cancellation for nonpayment of premium, is improper, coverage may be reinstated retroactive to the date of cancellation, rescission or nonrenewal. The Contractholder or the Primary Enrollee, if responsible for payment of premium, is responsible for the payment of any and all outstanding premium payments accrued from the effective date of the cancellation, rescission or nonrenewal before reinstatement. Any outstanding premium must be paid prior to reinstatement.

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OPTION 1 – YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

Grievances may be submitted online at deltadentalins.com, or

Cancellation - Nonpayment: call 800-765-6003 or write to:

Delta Dental of California

Attn: Correspondence Department

P.O. Box 997100

Sacramento, CA 95899

Cancellation - Rescission or Nonrenewal: call 866-275-1396 or write to:

DeltaCare USA

12898 Towne Center Drive

Cerritos, CA 90703-8579

Grievances may be submitted to Us first if the Primary Enrollee or Contractholder believes the cancellation, recession, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.

We will resolve the grievance or provide a pending status within three (3) calendar days. If a written response is not received from Us within three (3) calendar days, or if there is dissatisfaction with Our response in any way, a grievance may be submitted to the DMHC as detailed under Option 2 below.

OPTION 2 – YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DMHC.

Grievances may be submitted to the DMHC without first submitting it to Us or after receipt of Our decision on the grievance. Grievances may be submitted to the DMHC online at www.Healthhelp.ca.gov or in writing to:

Help Center

Department of Managed Health Care

980 Ninth Street, Suite 500

Sacramento, CA 95814-2725

You may contact the DMHC for more information on filing a grievance at:

Phone: 1-888-466-2219

TDD: 1-877-688-9891

Fax: 1-916-255-5241

- 4.05 In the event of cancellation of enrollment by Us, We will return to Contractholder the pro rata portion of the Premiums paid to Us which corresponds to any unexpired period for which payment had been received, together with any amounts due on claims, if any, less any amounts owed to Delta Dental. This provision does not apply if the Enrollee engaged in fraud or deception in obtaining Benefits from Us or knowingly permitted such fraud or deception by another.
- 4.06 Delta Dental may change the amount of Premiums whenever the terms of this Contract are changed by amendment of Section 6 - Group Information or whenever the Applicant requests a change in Benefits, eligibility or when due to a state and/or federal mandated change (new tax, assessment or fee is imposed on the amounts payable to, or by Delta Dental under this Contract). However, in the absence of an amendment mutually agreed upon between Applicant and Delta Dental or changes in Benefits, eligibility, or when due to a state and/or federal mandated change (new tax, assessment or fee is imposed on the amounts payable to, or by Delta Dental under this Contract), no change shall become effective in a Contract Term. The Premium amount stated in Section 6 – Group Information will be increased, upon 180 days written notice to Applicant, and this Contract shall thereby be modified on the date set forth in this notice.

Section 5. General Provisions

Entire Contract; Changes

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This Contract, including the EOC and any attachments, is the entire agreement between the parties. No agent has authority to change or waive any of its provisions. Changes are not valid unless approved by one of Our executive officers.

Severability

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

Conformity with Applicable Laws

All legal questions will be governed by the laws of the state where this Contract was entered into and is to be performed. Any part of this Contract which conflicts with state or federal law is hereby amended to conform to the minimum requirements of such laws.

Misstatements on Application; Effect

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

Misstatement of Age

If the age of the Enrollee has been misstated, the Premium will be adjusted to the amount of Premium payable had the age not been misstated.

Publications about Program

The parties agree to consult as is reasonably practical on all material published or distributed about this Contract. No material will be published or distributed which conflicts with the terms of this Contract.

Notice; Where Directed

All formal notices under this Contract must be in writing and sent by email, facsimile (fax), first-class United States mail, overnight delivery service or personal delivery. Notice by United States mail will be effective 48 hours after mailing with fully pre-paid postage.

Contractholder will designate, in writing, a representative for purposes of receiving notices from Us under this Contract. Contractholder may change its representative at any time with 30 days written notice to Us. The Contractholder's representative will provide notices to the Enrollees within 30 days of receipt.

Impossibility of Performance

Neither party will 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 strictly limited to include acts of God or of a public enemy, explosion, fire or unusually severe weather. Dates and times of performance will be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

Compliance with Administrative Simplification, Security and Privacy Regulations

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

Not in Lieu of Workers' Compensation

This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

Incontestability

After this Contract has been in force for 3 years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an Enrollee with respect to their

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insurability will be used to reduce or deny a claim or contest the validity of insurance for such Enrollee after that person's coverage has been in effect 3 years or more during his or her lifetime.

No claims for loss incurred or disability commencing after 3 years from the date of issue of this Contract will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Contract.

Third Party Administrator ("Administrator")

We may use the services of an Administrator or other designated representative, duly registered under applicable state law, to provide services under this Contract. Any Administrator providing such services or receiving such information will enter into a separate Business Associate Agreement ("BAA") with Us, providing that the Administrator will meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Mutual Confidentiality

The parties agree to maintain confidential information using the same degree of care (which will be no less than reasonable care) that each party 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 generally 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. 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.

Trademarks; Service Marks

Unless specifically allowed in this Contract, neither party will use the name, trademarks, service marks or other proprietary branding of the other party without the advance written approval of the other party.

Section 6. Group Information

Contractholder Name: San Bernardino County

Group Number: 78852

Effective Date: July 30, 2022

Contract Term: 60 Months

Premiums per Biweekly/Monthly

Plan Type: CAD90

Rates:

Contract Term: 07/30/2022 – 07/25/2025

Biweekly

| | |
|---|---------|
| Primary Enrollee: | \$8.44 |
| Primary Enrollee: Plus One Dependent Enrollee: | \$14.50 |
| Primary Enrollee: Plus Two or More Dependent Enrollees: | \$19.33 |

Monthly

| | |
|---|---------|
| Primary Enrollee: | \$18.28 |
| Primary Enrollee: Plus One Dependent Enrollee: | \$31.41 |
| Primary Enrollee: Plus Two or More Dependent Enrollees: | \$41.89 |

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Not to Exceed Rates:

Contract Term: 07/26/2025 – 07/23/2027

Biweekly

| | |
|---|----------|
| Primary Enrollee: | \$ 8.69 |
| Primary Enrollee: Plus One Dependent Enrollee: | \$ 14.94 |
| Primary Enrollee: Plus Two or More Dependent Enrollees: | \$ 19.91 |

Monthly

| | |
|---|----------|
| Primary Enrollee: | \$ 18.83 |
| Primary Enrollee: Plus One Dependent Enrollee: | \$ 32.35 |
| Primary Enrollee: Plus Two or More Dependent Enrollees: | \$ 43.15 |

Remit Premium Payment to: Attn: Accounts Receivable
Delta Dental Insurance Company or Administrator
PO Box 647006
Dallas, TX 75264-7006

Section 7. Attachments

The following documents are incorporated by reference:

Evidence of Coverage

Schedule A – Description of Benefits and Copayments

Schedule B – Limitations and Exclusions of Benefits

OCHA Notice for Fully Insured Groups

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SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in *italics* below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2022 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>ENROLLEE PAYS</u> |
|--------------------|---|--------------------------|
| D0100-D0999 | I. DIAGNOSTIC | |
| D0120 | Periodic oral evaluation - established patient | No Cost |
| D0140 | Limited oral evaluation - problem focused | No Cost |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | No Cost |
| D0150 | Comprehensive oral evaluation - new or established patient | No Cost |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | No Cost |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | No Cost |
| D0171 | Re-evaluation - post-operative office visit | \$5.00 |
| D0180 | Comprehensive periodontal evaluation - new or established patient | No Cost |
| D0190 | Screening of a patient | No Cost |
| D0191 | Assessment of a patient | No Cost |
| D0210 | Intraoral - complete series of radiographic images - <i>limited to 1 series every 24 months</i> | No Cost |
| D0220 | Intraoral - periapical first radiographic image | No Cost |
| D0230 | Intraoral - periapical each additional radiographic image | No Cost |
| D0240 | Intraoral - occlusal radiographic image | No Cost |
| D0250 | Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector | No Cost |
| D0251 | Extraoral posterior dental radiographic image | No Cost |
| D0270 | Bitewing - single radiographic image | No Cost |
| D0272 | Bitewings - two radiographic images | No Cost |
| D0273 | Bitewings three radiographic images | No Cost |
| D0274 | Bitewings - four radiographic images | No Cost |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | No Cost |
| D0330 | Panoramic radiographic image - <i>limited to 1 every 3 years</i> | No Cost |
| D0414 | Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report | No Cost |
| D0415 | Collection of microorganisms for culture and sensitivity | No Cost |
| D0419 | Assessment of salivary flow by measurement - <i>1 every 12 months</i> | No Cost |
| D0425 | Caries susceptibility tests | No Cost |

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| D0460 | Pulp vitality tests | No Cost |
| D0470 | Diagnostic casts | No Cost |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report | No Cost |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report | No Cost |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report | No Cost |
| D0601 | Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i> | No Cost |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i> | No Cost |
| D0603 | Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i> | No Cost |
| D0701 | Panoramic radiographic image - image capture only | No Cost |
| D0702 | 2-D cephalometric radiographic image - image capture only | No Cost |
| D0703 | 2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only | No Cost |
| D0704 | 3-D photographic image - image capture only | No Cost |
| D0705 | Extra-oral posterior dental radiographic image - image capture only | No Cost |
| D0706 | Intraoral - occlusal radiographic image - image capture only | No Cost |
| D0707 | Intraoral - periapical radiographic image - image capture only | No Cost |
| D0708 | Intraoral - bitewing radiographic image - image capture only | No Cost |
| D0709 | Intraoral - complete series of radiographic images - image capture only | No Cost |
| D0999 | Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i> | No Cost |

D1000-D1999 II. PREVENTIVE

| | | |
|-------|--|---------|
| D1110 | Prophylaxis <i>cleaning</i> - adult - 2 D1110, D1120 or D4346 per calendar year | No Cost |
| D1110 | <i>Additional prophylaxis cleaning - adult (In addition to the 2 allowed per calendar year)</i> | \$45.00 |
| D1120 | Prophylaxis <i>cleaning</i> - child - 2 D1110, D1120 or D4346 per calendar year | No Cost |
| D1120 | <i>Additional prophylaxis cleaning - child (In addition to the 2 allowed per calendar year)</i> | \$35.00 |
| D1206 | Topical application of fluoride varnish - <i>child to age 19; 2 D1206 or D1208 per calendar year</i> | No Cost |
| D1208 | Topical application of fluoride - excluding varnish - 2 D1206 or D1208 per calendar year | No Cost |
| D1310 | Nutritional counseling for control of dental disease | No Cost |
| D1330 | Oral hygiene instructions | No Cost |
| D1351 | Sealant - per tooth | \$5.00 |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient - permanent tooth | \$5.00 |
| D1353 | Sealant repair - per tooth | \$3.00 |
| D1354 | Application of caries arresting medicament - per tooth - 2 per calendar year | No Cost |
| D1510 | Space maintainer - fixed - unilateral - per quadrant | \$15.00 |
| D1516 | Space maintainer - fixed - bilateral, maxillary | \$15.00 |
| D1517 | Space maintainer - fixed - bilateral, mandibular | \$15.00 |
| D1520 | Space maintainer - removable - unilateral - per quadrant | \$15.00 |
| D1526 | Space maintainer - removable - bilateral, maxillary | \$15.00 |

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| D1527 | Space maintainer - removable - bilateral, mandibular | \$15.00 |
| D1551 | Re-cement or re-bond bilateral space maintainer - maxillary | No Cost |
| D1552 | Re-cement or re-bond bilateral space maintainer - mandibular | No Cost |
| D1553 | Re-cement or re-bond unilateral space maintainer - per quadrant | No Cost |
| D1556 | Removal of fixed unilateral space maintainer - per quadrant | No Cost |
| D1557 | Removal of fixed bilateral space maintainer - maxillary | No Cost |
| D1558 | Removal of fixed bilateral space maintainer - mandibular | No Cost |
| D1575 | Distal shoe space maintainer - fixed, unilateral - per quadrant - <i>child to age 9</i> | \$17.00 |

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$100.00 per crown, beyond the 6th unit.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

| | | |
|-------|---|----------|
| D2140 | Amalgam - one surface, primary or permanent | No Cost |
| D2150 | Amalgam - two surfaces, primary or permanent | No Cost |
| D2160 | Amalgam - three surfaces, primary or permanent | No Cost |
| D2161 | Amalgam - four or more surfaces, primary or permanent | No Cost |
| D2330 | Resin-based composite - one surface, anterior | No Cost |
| D2331 | Resin-based composite - two surfaces, anterior | No Cost |
| D2332 | Resin-based composite - three surfaces, anterior | No Cost |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | No Cost |
| D2390 | Resin-based composite crown, anterior | No Cost |
| D2391 | Resin-based composite - one surface, posterior | \$45.00 |
| D2392 | Resin-based composite - two surfaces, posterior | \$55.00 |
| D2393 | Resin-based composite - three surfaces, posterior | \$65.00 |
| D2394 | Resin-based composite - four or more surfaces, posterior | \$75.00 |
| D2510 | Inlay - metallic - one surface | No Cost |
| D2520 | Inlay - metallic - two surfaces | No Cost |
| D2530 | Inlay - metallic - three or more surfaces | No Cost |
| D2542 | Onlay - metallic - two surfaces | No Cost |
| D2543 | Onlay - metallic - three surfaces | No Cost |
| D2544 | Onlay - metallic - four or more surfaces | No Cost |
| D2610 | Inlay - porcelain/ceramic - one surface | \$135.00 |
| D2620 | Inlay - porcelain/ceramic - two surfaces | \$150.00 |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces | \$160.00 |
| D2642 | Onlay - porcelain/ceramic - two surfaces | \$150.00 |
| D2643 | Onlay - porcelain/ceramic - three surfaces | \$165.00 |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces | \$175.00 |
| D2650 | Inlay - resin-based composite - one surface | \$85.00 |
| D2651 | Inlay - resin-based composite - two surfaces | \$95.00 |
| D2652 | Inlay - resin-based composite - three or more surfaces | \$115.00 |
| D2662 | Onlay - resin-based composite - two surfaces | \$110.00 |
| D2663 | Onlay - resin-based composite - three surfaces | \$120.00 |
| D2664 | Onlay - resin-based composite - four or more surfaces | \$145.00 |
| D2710 | Crown - resin-based composite (indirect) | \$40.00 |
| D2712 | Crown - 3/4 resin-based composite (indirect) | \$40.00 |
| D2720 | Crown - resin with high noble metal | \$160.00 |
| D2721 | Crown - resin with predominantly base metal | \$60.00 |

EXHIBIT C

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| D2722 | Crown - resin with noble metal | \$60.00 |
| D2740 | Crown - porcelain/ceramic | \$60.00 |
| D2750 | Crown - porcelain fused to high noble metal | \$160.00 |
| D2751 | Crown - porcelain fused to predominantly base metal | \$60.00 |
| D2752 | Crown - porcelain fused to noble metal | \$60.00 |
| D2753 | Crown - porcelain fused to titanium and titanium alloys | \$160.00 |
| D2780 | Crown - 3/4 cast high noble metal | \$160.00 |
| D2781 | Crown - 3/4 cast predominantly base metal | \$60.00 |
| D2782 | Crown - 3/4 cast noble metal | \$60.00 |
| D2783 | Crown - 3/4 porcelain/ceramic | \$195.00 |
| D2790 | Crown - full cast high noble metal | \$160.00 |
| D2791 | Crown - full cast predominantly base metal | \$60.00 |
| D2792 | Crown - full cast noble metal | \$60.00 |
| D2794 | Crown - titanium and titanium alloys | \$160.00 |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | No Cost |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | No Cost |
| D2920 | Re-cement or re-bond crown | No Cost |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>) | No Cost |
| D2928 | Prefabricated porcelain/ceramic crown - permanent tooth | No Cost |
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i> | \$10.00 |
| D2930 | Prefabricated stainless steel crown - primary tooth | No Cost |
| D2931 | Prefabricated stainless steel crown - permanent tooth | No Cost |
| D2932 | Prefabricated resin crown - <i>anterior primary tooth</i> | \$10.00 |
| D2933 | Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i> | \$10.00 |
| D2940 | Protective restoration | \$10.00 |
| D2941 | Interim therapeutic restoration - primary dentition | \$10.00 |
| D2949 | Restorative foundation for an indirect restoration | \$10.00 |
| D2950 | Core buildup, including any pins when required | \$10.00 |
| D2951 | Pin retention - per tooth, in addition to restoration | \$10.00 |
| D2952 | Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> | \$10.00 |
| D2953 | Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> | \$10.00 |
| D2954 | Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i> | \$10.00 |
| D2957 | Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i> | \$10.00 |
| D2971 | Additional procedures to customize a crown to fit under an existing partial denture framework. | \$12.00 |
| D2980 | Crown repair necessitated by restorative material failure | \$10.00 |
| D2981 | Inlay repair necessitated by restorative material failure | \$10.00 |
| D2982 | Onlay repair necessitated by restorative material failure | \$10.00 |
| D2983 | Veneer repair necessitated by restorative material failure | \$10.00 |
| D2990 | Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars</i> | \$5.00 |

D3000-D3999 IV. ENDODONTICS

| | | |
|-------|---|---------|
| D3110 | Pulp cap - direct (excluding final restoration) | No Cost |
| D3120 | Pulp cap - indirect (excluding final restoration) | No Cost |

EXHIBIT C

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| D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | No Cost |
| D3221 | Pulpal debridement, primary and permanent teeth | \$6.00 |
| D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | No Cost |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | \$6.00 |
| D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | \$6.00 |
| D3310 | <i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) | \$30.00 |
| D3320 | <i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration) | \$60.00 |
| D3330 | <i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration) | \$90.00 |
| D3331 | Treatment of root canal obstruction; non-surgical access | \$45.00 |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | \$45.00 |
| D3333 | Internal root repair of perforation defects | \$45.00 |
| D3346 | Retreatment of previous root canal therapy - anterior | \$45.00 |
| D3347 | Retreatment of previous root canal therapy - premolar | \$75.00 |
| D3348 | Retreatment of previous root canal therapy - molar | \$105.00 |
| D3351 | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | \$70.00 |
| D3352 | Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | \$45.00 |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | \$45.00 |
| D3410 | Apicoectomy - anterior | \$50.00 |
| D3421 | Apicoectomy - premolar (first root) | \$50.00 |
| D3425 | Apicoectomy - molar (first root) | \$50.00 |
| D3426 | Apicoectomy (each additional root) | No Cost |
| D3430 | Retrograde filling - per root | \$50.00 |
| D3450 | Root amputation - per root (<i>Not covered in conjunction with Procedure D3920</i>) | No Cost |
| D3471 | Surgical repair of root resorption - anterior | \$50.00 |
| D3472 | Surgical repair of root resorption - premolar | \$50.00 |
| D3473 | Surgical repair of root resorption - molar | \$50.00 |
| D3501 | Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior | \$50.00 |
| D3502 | Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar | \$50.00 |
| D3503 | Surgical exposure of root surface without apicoectomy or repair of root resorption - molar | \$50.00 |
| D3920 | Hemisection (including any root removal), not including root canal therapy | No Cost |
| D3921 | Decoronation or submergence of an erupted tooth | No Cost |

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D4000-D4999 V. PERIODONTICS

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

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|-------|--|----------|
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | \$75.00 |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | \$15.00 |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | \$15.00 |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | \$75.00 |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | \$75.00 |
| D4245 | Apically positioned flap | \$75.00 |
| D4249 | Clinical crown lengthening - hard tissue | \$75.00 |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | \$150.00 |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | \$150.00 |
| D4263 | Bone replacement graft - retained natural tooth - first site in quadrant | \$195.00 |
| D4264 | Bone replacement graft - retained natural tooth - each additional site in quadrant | \$60.00 |
| D4270 | Pedicle soft tissue graft procedure | \$195.00 |
| D4274 | Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) | \$45.00 |
| D4277 | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft | \$195.00 |
| D4278 | Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site | \$100.00 |
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> | No Cost |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> | No Cost |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i> | No Cost |
| D4355 | Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i> | No Cost |
| D4910 | Periodontal maintenance - <i>limited to 2 per calendar year (only covered after active therapy)</i> | No Cost |
| D4910 | <i>Additional periodontal maintenance (beyond 2 per calendar year) ...</i> | \$55.00 |
| D4921 | Gingival irrigation - per quadrant | No Cost |

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after

EXHIBIT C

placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

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

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

- Interim dentures are limited to initial placement of interim partial denture/stayplate to replace extracted anterior tooth during healing.

| | | |
|-------|--|----------|
| D5110 | Complete denture - maxillary | \$75.00 |
| D5120 | Complete denture - mandibular | \$75.00 |
| D5130 | Immediate denture - maxillary | \$90.00 |
| D5140 | Immediate denture - mandibular | \$90.00 |
| D5211 | Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$85.00 |
| D5212 | Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$85.00 |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$85.00 |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$85.00 |
| D5221 | Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$90.00 |
| D5222 | Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$90.00 |
| D5223 | Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$90.00 |
| D5224 | Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$90.00 |
| D5225 | Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) | \$135.00 |
| D5226 | Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) | \$135.00 |
| D5227 | Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) | \$90.00 |
| D5228 | Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) | \$90.00 |
| D5410 | Adjust complete denture - maxillary | No Cost |
| D5411 | Adjust complete denture - mandibular | No Cost |
| D5421 | Adjust partial denture - maxillary | No Cost |
| D5422 | Adjust partial denture - mandibular | No Cost |
| D5511 | Repair broken complete denture base, mandibular | \$15.00 |
| D5512 | Repair broken complete denture base, maxillary | \$15.00 |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | \$5.00 |
| D5611 | Repair resin partial denture base, mandibular | \$15.00 |
| D5612 | Repair resin partial denture base, maxillary | \$15.00 |
| D5621 | Repair cast partial framework, mandibular | \$15.00 |
| D5622 | Repair cast partial framework, maxillary | \$15.00 |
| D5630 | Repair or replace broken retentive/clasping materials - per tooth | \$15.00 |
| D5640 | Replace broken teeth - per tooth | \$5.00 |
| D5650 | Add tooth to existing partial denture | \$5.00 |
| D5660 | Add clasp to existing partial denture - per tooth | \$5.00 |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | \$75.00 |

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| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | \$75.00 |
| D5710 | Rebase complete maxillary denture | \$30.00 |
| D5711 | Rebase complete mandibular denture | \$30.00 |
| D5720 | Rebase maxillary partial denture | \$30.00 |
| D5721 | Rebase mandibular partial denture | \$30.00 |
| D5725 | Rebase hybrid prosthesis | \$30.00 |
| D5730 | Reline complete maxillary denture (chairside) | \$15.00 |
| D5731 | Reline complete mandibular denture (chairside) | \$15.00 |
| D5740 | Reline maxillary partial denture (chairside) | \$15.00 |
| D5741 | Reline mandibular partial denture (chairside) | \$15.00 |
| D5750 | Reline complete maxillary denture (laboratory) | \$30.00 |
| D5751 | Reline complete mandibular denture (laboratory) | \$30.00 |
| D5760 | Reline maxillary partial denture (laboratory) | \$30.00 |
| D5761 | Reline mandibular partial denture (laboratory) | \$30.00 |
| D5765 | Soft liner for complete or partial removable denture - indirect | \$30.00 |
| D5820 | Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary | No Cost |
| D5821 | Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular | No Cost |
| D5850 | Tissue conditioning, maxillary | No Cost |
| D5851 | Tissue conditioning, mandibular | No Cost |

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$100.00 per crown, beyond the 6th unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

| | | |
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| D6210 | Pontic - cast high noble metal | \$160.00 |
| D6211 | Pontic - cast predominantly base metal | \$60.00 |
| D6212 | Pontic - cast noble metal | \$60.00 |
| D6240 | Pontic - porcelain fused to high noble metal | \$160.00 |
| D6241 | Pontic - porcelain fused to predominantly base metal | \$60.00 |
| D6242 | Pontic - porcelain fused to noble metal | \$60.00 |
| D6243 | Pontic - porcelain fused to titanium and titanium alloys | \$60.00 |
| D6245 | Pontic - porcelain/ceramic | \$195.00 |
| D6250 | Pontic - resin with high noble metal | \$160.00 |
| D6251 | Pontic - resin with predominantly base metal | \$60.00 |
| D6252 | Pontic - resin with noble metal | \$60.00 |
| D6600 | Retainer inlay - porcelain/ceramic, two surfaces | \$150.00 |
| D6601 | Retainer inlay - porcelain/ceramic, three or more surfaces | \$160.00 |
| D6602 | Retainer inlay - cast high noble metal, two surfaces | No Cost |
| D6603 | Retainer inlay - cast high noble metal, three or more surfaces | No Cost |
| D6604 | Retainer inlay - cast predominantly base metal, two surfaces | No Cost |
| D6605 | Retainer inlay - cast predominantly base metal, three or more surfaces | No Cost |
| D6606 | Retainer inlay - cast noble metal, two surfaces | No Cost |
| D6607 | Retainer inlay - cast noble metal, three or more surfaces | No Cost |

EXHIBIT C

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| D6608 | Retainer onlay - porcelain/ceramic, two surfaces | \$150.00 |
| D6609 | Retainer onlay - porcelain/ceramic, three or more surfaces | \$165.00 |
| D6610 | Retainer onlay - cast high noble metal, two surfaces | No Cost |
| D6611 | Retainer onlay - cast high noble metal, three or more surfaces | No Cost |
| D6612 | Retainer onlay - cast predominantly base metal, two surfaces | No Cost |
| D6613 | Retainer onlay - cast predominantly base metal, three or more surfaces | No Cost |
| D6614 | Retainer onlay - cast noble metal, two surfaces | No Cost |
| D6615 | Retainer onlay - cast noble metal, three or more surfaces | No Cost |
| D6720 | Retainer crown - resin with high noble metal | \$160.00 |
| D6721 | Retainer crown - resin with predominantly base metal | \$60.00 |
| D6722 | Retainer crown - resin with noble metal | \$60.00 |
| D6740 | Retainer crown - porcelain/ceramic | \$195.00 |
| D6750 | Retainer crown - porcelain fused to high noble metal | \$160.00 |
| D6751 | Retainer crown - porcelain fused to predominantly base metal | \$60.00 |
| D6752 | Retainer crown - porcelain fused to noble metal | \$60.00 |
| D6753 | Retainer crown - porcelain fused to titanium and titanium alloys | \$160.00 |
| D6780 | Retainer crown - 3/4 cast high noble metal | \$160.00 |
| D6781 | Retainer crown - 3/4 cast predominantly base metal | \$60.00 |
| D6782 | Retainer crown - 3/4 cast noble metal | \$60.00 |
| D6783 | Retainer crown - 3/4 porcelain/ceramic | \$195.00 |
| D6784 | Retainer crown - titanium and titanium alloys | \$160.00 |
| D6790 | Retainer crown - full cast high noble metal | \$160.00 |
| D6791 | Retainer crown - full cast predominantly base metal | \$60.00 |
| D6792 | Retainer crown - full cast noble metal | \$60.00 |
| D6930 | Re-cement or re-bond fixed partial denture | No Cost |
| D6940 | Stress breaker | No Cost |
| D6980 | Fixed partial denture repair necessitated by restorative material failure | \$15.00 |

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

- Extractions solely for orthodontic purposes are not covered.

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| D7111 | Extraction, coronal remnants - primary tooth | No Cost |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | No Cost |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | No Cost |
| D7220 | Removal of impacted tooth - soft tissue | No Cost |
| D7230 | Removal of impacted tooth - partially bony | \$30.00 |
| D7240 | Removal of impacted tooth - completely bony | \$40.00 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | \$40.00 |
| D7250 | Removal of residual tooth roots (cutting procedure) | No Cost |
| D7251 | Coronectomy - intentional partial tooth removal | No Cost |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | \$50.00 |
| D7280 | Exposure of an unerupted tooth | \$85.00 |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | \$85.00 |
| D7283 | Placement of device to facilitate eruption of impacted tooth | No Cost |
| D7286 | Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i> | No Cost |

EXHIBIT C

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| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$30.00 |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$30.00 |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$40.00 |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$40.00 |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | No Cost |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm | No Cost |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | No Cost |
| D7472 | Removal of torus palatinus | No Cost |
| D7473 | Removal of torus mandibularis | No Cost |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | No Cost |
| D7922 | Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site | No Cost |
| D7961 | Buccal/labial frenectomy (frenulectomy) | No Cost |
| D7962 | Lingual frenectomy (frenulectomy) | No Cost |
| D7970 | Excision of hyperplastic tissue - per arch | \$50.00 |
| D7971 | Excision of pericoronal gingiva | \$50.00 |

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee may apply.

- The Retention Copayment includes adjustments and/or office visits up to 24 months.

- In addition to the codes listed below, Pre and post orthodontic records may include any of the Intraoral, Extraoral or Bitewing codes listed in the Diagnostic section.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes:

\$300.00

| | |
|-------|---|
| D0210 | Intraoral - complete series of radiographic images |
| D0251 | Extraoral posterior dental radiographic image |
| D0322 | Tomographic survey |
| D0330 | Panoramic radiographic image |
| D0340 | 2D cephalometric radiographic image - acquisition, measurement and analysis |
| D0350 | 2D oral/facial photographic images obtained intraorally or extraorally |
| D0351 | 3D photographic image |
| D0470 | Diagnostic casts |

The benefit for post-treatment records includes: \$120.00

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| D0210 | Intraoral - complete series of radiographic images |
| D0470 | Diagnostic casts |

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| D8010 | Limited orthodontic treatment of the primary dentition | \$230.00 |
| D8020 | Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> | \$230.00 |

EXHIBIT C

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| D8030 | Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> | \$230.00 |
| D8040 | Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> | \$430.00 |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> | \$490.00 |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> | \$490.00 |
| D8090 | Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> | \$490.00 |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development (<i>Enrollee pays a \$25.00 fee if orthodontic treatment is not required or is declined by the Enrollee</i>) | No Cost |
| D8670 | Periodic orthodontic treatment visit (<i>Charge per month for 24 months</i>) | \$40.00 |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers) | No Cost |
| D8681 | Removable orthodontic retainer adjustment | No Cost |
| D8999 | Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i> | \$200.00 |

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

| | | |
|-------|---|---------|
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure .. | \$5.00 |
| D9211 | Regional block anesthesia | No Cost |
| D9212 | Trigeminal division block anesthesia | No Cost |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | No Cost |
| D9219 | Evaluation for moderate sedation, deep sedation or general anesthesia | No Cost |
| D9222 | Deep sedation/general anesthesia - first 15 minutes | \$83.00 |
| D9223 | Deep sedation/general anesthesia - each subsequent 15 minute increment | \$83.00 |
| D9239 | Intravenous moderate (conscious) sedation/analgesia - first 15 minutes | \$83.00 |
| D9243 | Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment | \$83.00 |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | No Cost |
| D9311 | Consultation with a medical health care professional | No Cost |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | \$5.00 |
| D9440 | Office visit - after regularly scheduled hours | \$20.00 |
| D9450 | Case presentation, detailed and extensive treatment planning | No Cost |
| D9912 | Pre-visit patient screening | \$0.00 |
| D9932 | Cleaning and inspection of removable complete denture, maxillary .. | No Cost |
| D9933 | Cleaning and inspection of removable complete denture, mandibular | No Cost |
| D9934 | Cleaning and inspection of removable partial denture, maxillary | No Cost |
| D9935 | Cleaning and inspection of removable partial denture, mandibular ... | No Cost |
| D9943 | Occlusal guard adjustment | \$10.00 |
| D9944 | Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 24 months</i> | \$95.00 |
| D9945 | Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 24 months</i> | \$95.00 |
| D9946 | Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 24 months</i> | \$95.00 |

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| D9951 | Occlusal adjustment, limited | \$20.00 |
| D9952 | Occlusal adjustment, complete | \$40.00 |
| D9975 | External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i> | \$125.00 |
| D9986 | Missed appointment - <i>without 24 hour notice</i> | \$10.00 |
| D9987 | Canceled appointment - <i>without 24 hour notice</i> | \$10.00 |
| D9990 | Certified translation or sign-language services - per visit | No Cost |
| D9991 | Dental case management - addressing appointment compliance barriers | No Cost |
| D9992 | Dental case management - care coordination | No Cost |
| D9995 | Teledentistry - synchronous; real-time encounter | No Cost |
| D9996 | Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review | No Cost |
| D9997 | Dental case management - Patients with special Health Care Needs | No Cost |

Procedures with age restrictions will be subject to exceptions based on medical necessity.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Us. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*. *(Frequency limitations on diagnostic and preventive procedures do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist)*.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's standard fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

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Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
 - b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations for non-covered benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Prescription drugs.

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12. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
13. Lost, stolen or broken orthodontic appliances.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies.
16. Composite or ceramic brackets, lingual adaptation of orthodontic bands.
17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
18. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
19. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

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OHCA Contract Notice for Fully Insured Groups

Delta Dental of California ("Delta Dental") and the fully insured Group Health Plan ("Contractholder") participate in an Organized Health Care Arrangement (as defined in 45 Code of Federal Regulations (C.F.R.) §164.501) ("OHCA"). The Contractholder hereby certifies that:

- The Contractholder will treat all PHI in accordance with the standards of the HIPAA Privacy Rules and update its plan documents to reflect that it will limit access to PHI to those employees and authorized representatives of the Contractholder whose access is necessary to perform the plan administration functions permitted under the HIPAA Privacy Rules and that PHI will not be used in the context of other benefit plans or in employment-related decisions.
- In order for PHI beyond summary health information to be disclosed, the fully insured Contractholder must: (1) provide a signed attestation that their plan documents have been amended to comply with the applicable HIPAA privacy administrative safeguard provisions; (2) have issued a HIPAA compliant privacy notice; and (3) provide individuals with the right to access, review, amend, and receive an accounting of disclosures.
- PHI requested is the minimum necessary for the Contractholder to perform its health care operations and/or payment activities related to the Contract herein.
- If Delta Dental is directed to release PHI to a third party, the third party has a HIPAA compliant BAA with the Contractholder.

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DeltaCare® USA
Dental Health Care Program for Eligible Employees and Dependents
Evidence of Coverage
San Bernardino County

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Definitions

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

Administrator means Delta Dental Insurance Company, a third party entity designated to perform administrative functions described throughout the Contract, including, but not limited to, the collection of Premium and eligibility.

Benefits: Dental services provided by Us in this EOC, the Contract and Schedules. See also Schedules.

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

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

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

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

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

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

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

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

Emergency Service means care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: (i) placing the Enrollee's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

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

Open Enrollment Period means the period requested by the Client and agreed to by Delta Dental.

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Out-of-Network means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.

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

Reasonable means that an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Contract Dentist to obtain Emergency Services and, in the event the Dentist is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Dentist.

Special Health Care Need means a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are 1) the Enrollee's inability to obtain access to the assigned Contract Dentist's facility because of a physical disability and 2) the Enrollee's inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

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

Spouse means 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 this 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.*

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Treatment In Progress means any single dental procedure, as defined by the CDT Code, that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under the DeltaCare USA plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

We, Us or Our means Delta Dental of California or the Administrator as appropriate.

Eligibility for Benefits

The benefit must be offered to you through a Memorandum of Understanding (MOU), Exempt Compensation Plan, salary ordinance or contract.

Employee Eligibility

- 1) An eligible employee is an individual who meets one of the following: Is employed by the County and meeting eligibility requirements established in the employee's MOU, Exempt Compensation Plan, salary ordinance or contract.*
- 2) Is employed by the County and meeting eligibility requirements established in the employee's MOU, Exempt Compensation Plan, salary ordinance or contract, but unable to work due to a federal or state-protected leave of absence.*
- 3) Is employed by a district governed by the County Board of Supervisors or an entity affiliated with the County that has adopted this Plan and meeting eligibility requirements established in the employee's MOU, Exempt Compensation Plan, salary ordinance or contract.*
- 4) Has entered into an employment contract with the County or a district governed by the County Board of Supervisors or a government entity affiliated with the County that has adopted this Plan which includes the provision of dental benefits.*

Dependent Eligibility

If you are eligible to participate in County-sponsored dental plans, your eligible spouse, domestic partner or dependents may also participate if they meet one of the following criteria:

- 1) Legal spouse or state-registered domestic partner.*
- 2) Your qualifying children which includes children up to age 26 that are born to you, your stepchildren, children legally adopted by you (including children legally placed in your home while finalization of adoption is pending), children for whom you are the permanent legal guardian, children of a domestic partner, and children you support as a result of a valid court order.*
- 3) An overage dependent child may be eligible if:
a) he or she is incapable of self-sustaining employment because of*

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- a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;*
- b) he or she is chiefly dependent on you for support; and*
- c) proof of dependent's disability is provided within 60 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 you for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.*

Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates, and relatives other than those listed above are not eligible for County-sponsored dental plans.

Prepayment Fees/Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly.

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We may cancel the Contract 30 days after written notice to the Client if monthly premiums are not paid when due. The Client will be given a 60 day grace period, which begins immediately following the last day of paid coverage, to pay the monthly premium. During that time, Delta Dental will continue to provide coverage to Enrollees. If the premium remains unpaid at the end of the 60 day grace period, the Contractholder will notify you that coverage has terminated along with the date of termination.

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

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 855-244-7323. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 855-244-7323.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED IN WRITING BY DELTA DENTAL, OR FOR EMERGENCY SERVICES AS PROVIDED IN EMERGENCY SERVICES. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (1) a partial or full denture for which final impressions have been taken, and (2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Continuity of Care

Current Members:

You may have the right to the benefit of completion of care with

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your terminated Dentist for certain specified dental conditions. Please call Customer Service at 855-244-7323 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your terminated Dentist on the terms regarding your care in accordance with California law.

New Members:

You may have the right to the qualified benefit of completion of care with an Out-of-Network Dentist for certain specified dental conditions. Please call the Customer Service department at 855-244-7323 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your Dentist on the terms regarding your care in accordance with California law. This policy does not apply to new Members of an individual subscriber contract.

Special Needs

If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at 855-244-7323. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 855-244-7323.

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Benefits, Limitations and Exclusions

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

Copayments and Other Charges

In order to keep Your Plan affordable, this Plan includes certain cost-sharing features. First, not all dental services or procedure may be included under Your Plan. If the procedure is not listed in the Schedules, it is not covered. You will be responsible to pay the Dentist the full charge for any service not included in Your Plan. Certain procedures require You to pay a Copayment. Copayments are listed in the Schedules and must be paid directly to the treating Dentist. Any charges for broken appointments and visits after normal visiting hours, if covered, are also listed in the Schedules.

Emergency Services

If Emergency Services are needed, you should contact your Contract Dentist whenever possible. If you are a new Enrollee needing Emergency Services, but do not have an assigned Contract Dentist yet, contact Delta Dental's Customer Service department at 855-244-7323 for help in locating a Contract Dentist. Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

- 1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or you cannot be seen within 24 hours of making contact; or*
- 2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or*
- 3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Services.*

Benefits for Emergency Services not provided by the Contract Dentist are limited to a maximum of \$100.00 per emergency, per Enrollee, less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a provider other than your Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

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

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 855-244-7323 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the plan or with the Department of Managed Health Care. Refer to the Enrollee Complaint Procedure section for more information.

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare

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USA provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in Emergency Services, if you have not received Preauthorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown on the back cover of this booklet.

Processing Policies

The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental Program are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at 855-244-7323 for information regarding the dental care guidelines for DeltaCare USA.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

If this plan is secondary, it will pay the lesser of:

- 1) the amount that it would have paid in the absence of any other dental benefit coverage, or*

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- 2) *the enrollee's total out-of-pocket cost payable under the primary dental benefit plan as long as the benefits are covered under this plan.*

An Enrollee shall provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefit paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 855-244-7323, or the complaint may be addressed in writing to:

*Quality Management Department
P.O. Box 6050
Artesia, CA 90702*

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

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you may file a request for review (a complaint) with Delta Dental at least 180 days after receipt of the adverse determination. Delta Dental's review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, Delta Dental will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting

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Dentist will be available upon request.

Within 5 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee notification regarding the disposition or pending status of the complaint shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 855-244-7323 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

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

Public Policy Participation by Enrollees

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Customer Service Department, P.O. Box 1803, Alpharetta, GA 30023.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless Delta Dental provides notice of a change in premiums or Benefits and the Client does not accept the change.

When Coverage Ends

Employees

Your benefits will cease on the earliest date below:

- 1) The last day for which you have made any required contribution for the coverage.*
- 2) The date the policy is canceled*
- 3) The last day of the Pay Period in which you no longer meet Employee Eligibility as defined in the Eligibility section above..*

Dependents

The benefits for all of your Dependent Enrollees will cease on the earliest date below:

- 1) The date your coverage ceases.*
- 2) The date your Dependent(s) cease to be eligible for coverage.*
- 3) The last day for which you have made any required contribution for the coverage.*

Your Dependent Enrollee's coverage ends when yours does, or the pay period in which they are no longer eligible Dependents.

SCHEDULE C

Cancellation of Enrollment

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

- 1) immediately:*
 - a) upon loss of eligibility as described in this Evidence of Coverage;*
or
- 2) upon 30 days written notice if:*
 - a) the Contract is terminated or not renewed;*
 - b) the Premium is not paid by or on behalf of the Enrollee on the date due. However, the Enrollee may continue to receive Benefits during the 60-day grace period and may be renewed at the end of the Contract Term upon payment of any unpaid Premium; or*
 - c) Delta Dental demonstrates that the Enrollee committed fraud or an intentional misrepresentation of material fact in obtaining Benefits under the Program.*

Cancellation of a Primary Enrollee's enrollment, as described above, shall automatically cancel the enrollment of any of his or her Dependent Enrollees. Any cancellation is subject to the written notification requirements set forth in the Contract and in California law.

If you believe that enrollment has been improperly cancelled, rescinded or not renewed, you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to the Enrollee Complaint Procedure section for more information.

Optional Continuation of Coverage (COBRA)

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, at your expense, if certain conditions are met. The period of continued coverage depends on the Qualifying Event and whether the Enrollee is covered under federal COBRA.

SCHEDULE C

DEFINITIONS

The meaning of key terms used in this section is shown below and applies to federal COBRA.

Qualified Beneficiary means:

- 1) Enrollees who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or*
- 2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.*

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

- Event 1. the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;*
- Event 2. your death;*
- Event 3. your divorce or legal separation from your spouse;*
- Event 4. your dependent's loss of dependent status under the plan; and*
- Event 5. as to your dependents only, your entitlement to Medicare.*

You or your means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE UNDER FEDERAL COBRA

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs. This 18-month period can be extended for a total of 29 months, provided:

- 1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and*
- 2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.*

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

SCHEDULE C

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

Under federal COBRA law only, when an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

A Qualified Beneficiary will have 60 days from a Qualifying Event to give Delta Dental written notice of the election to continue coverage.

Upon written notice, Delta Dental will provide a Qualified Beneficiary with the necessary Benefits information, monthly premium charge, enrollment forms and instructions to allow election of continued coverage.

Failure to provide this written notice of election to Delta Dental within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to Delta Dental, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in the loss of the right to continue coverage and any premiums received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the

SCHEDULE C

month in which any of the following events first occur:

- 1) the allowable number of consecutive months of continued coverage is reached;*
- 2) failure to pay the required premiums in a timely manner;*
- 3) the employer ceases to provide any group dental plan to its employees;*
- 4) the individual moves out of the plan's service area;*
- 5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or*
- 6) entitlement to Medicare.*

Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

SCHEDULE C

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Non-Discrimination

Delta Dental is committed to ensuring that no person is excluded from, or denied the benefits of our services, or otherwise discriminated against on the basis of race, color, national origin, disability, age, genetic testing, sexual orientation or gender identity. Any person who believes that he or she has individually, or as a member of any specific class of persons, been subjected to discrimination may file a complaint in writing to:

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

Timely Access to Care

Contract Dentists, Contract Orthodontists, and Contract Specialists have agreed waiting times to Enrollees for appointments for care will never be greater than the following time frames:

- a. For emergency care, 24 hours a day, 7 day days a week;*
- b. For any urgent care, 72 hours for appointments consistent with the patient's individual needs;*
- c. For any non-urgent care, 36 business days; and*
- d. For any preventative services, 40 business days.*

During non-business hours, the Enrollee will have access to their Provider's answering machine, answering service, cell phone, or pager for guidance on what to do and who to contact if the Enrollee is calling due to an emergency or urgent care situation.

If an Enrollee calls our plan's customer service phone number, a Customer Service Representative will answer the phone within 10 minutes during normal business hours. Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentists, Contract Orthodontists and Contract Specialists offices please call 855-244-7323 for assistance.

SCHEDULE C

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2022 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA").

The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>ENROLLEE PAYS</u> |
|-------------|--|--------------------------|
| D0100-D0999 | I. DIAGNOSTIC | |
| D0120 | <i>Periodic oral evaluation - established patient</i> | <i>No Cost</i> |
| D0140 | <i>Limited oral evaluation - problem focused.....</i> | <i>No Cost</i> |
| D0145 | <i>Oral evaluation for a patient under three years of age and counseling with primary caregiver.....</i> | <i>No Cost</i> |
| D0150 | <i>Comprehensive oral evaluation - new or established patient.....</i> | <i>No Cost</i> |
| D0160 | <i>Detailed and extensive oral evaluation - problem focused, by report.....</i> | <i>No Cost</i> |
| D0170 | <i>Re-evaluation - limited, problem focused (established patient; not post-operative visit)</i> | <i>No Cost</i> |
| D0171 | <i>Re-evaluation - post-operative office visit</i> | <i>\$5.00</i> |
| D0180 | <i>Comprehensive periodontal evaluation - new or established patient.....</i> | <i>No Cost</i> |
| D0190 | <i>Screening of a patient</i> | <i>No Cost</i> |
| D0191 | <i>Assessment of a patient.....</i> | <i>No Cost</i> |
| D0210 | <i>Intraoral - complete series of radiographic images - limited to 1 series every 24 months.....</i> | <i>No Cost</i> |

SCHEDULE C

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| D0220 | Intraoral - periapical first radiographic image..... | No Cost |
| D0230 | Intraoral - periapical each additional radiographic image | No Cost |
| D0240 | Intraoral - occlusal radiographic image | No Cost |
| D0250 | Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector..... | No Cost |
| D0251 | Extraoral posterior dental radiographic image | No Cost |
| D0270 | Bitewing - single radiographic image | No Cost |
| D0272 | Bitewings - two radiographic images | No Cost |
| D0273 | Bitewings three radiographic images..... | No Cost |
| D0274 | Bitewings - four radiographic images | No Cost |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | No Cost |
| D0330 | Panoramic radiographic image - limited to 1 every 3 years..... | No Cost |
| D0414 | Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report | No Cost |
| D0415 | Collection of microorganisms for culture and sensitivity | No Cost |
| D0419 | Assessment of salivary flow by measurement - 1 every 12 months | No Cost |
| D0425 | Caries susceptibility tests | No Cost |
| D0460 | Pulp vitality tests | No Cost |
| D0470 | Diagnostic casts | No Cost |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report..... | No Cost |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report..... | No Cost |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report..... | No Cost |
| D0601 | Caries risk assessment and documentation, with a finding of low risk - 1 every 12 months | No Cost |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk - 1 every 12 months..... | No Cost |
| D0603 | Caries risk assessment and documentation, with a finding of high risk - 1 every 12 months..... | No Cost |

SCHEDULE C

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| D0701 | Panoramic radiographic image - image capture only | No Cost |
| D0702 | 2-D cephalometric radiographic image - image capture only..... | No Cost |
| D0703 | 2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only | No Cost |
| D0704 | 3-D photographic image - image capture only..... | No Cost |
| D0705 | Extra-oral posterior dental radiographic image - image capture only | No Cost |
| D0706 | Intraoral - occlusal radiographic image - image capture only..... | No Cost |
| D0707 | Intraoral - periapical radiographic image - image capture only..... | No Cost |
| D0708 | Intraoral - bitewing radiographic image - image capture only..... | No Cost |
| D0709 | Intraoral - complete series of radiographic images - image capture only | No Cost |
| D0999 | Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services) | No Cost |
| | | |
| D1000-D1999 | II. PREVENTIVE | |
| D1110 | Prophylaxis cleaning- adult - 2 D1110, D1120 or D4346 per calendar year | No Cost |
| D1110 | Additional prophylaxis cleaning - adult (In addition to the 2 allowed per calendar year) | \$45.00 |
| D1120 | Prophylaxis cleaning - child - 2 D1110, D1120 or D4346 per calendar year | No Cost |
| D1120 | Additional prophylaxis cleaning - child (In addition to the 2 allowed per calendar year) | \$35.00 |
| D1206 | Topical application of fluoride varnish - child to age 19; 2 D1206 or D1208 per calendar year..... | No Cost |
| D1208 | Topical application of fluoride - excluding varnish - 2 D1206 or D1208 per calendar year..... | No Cost |
| D1310 | Nutritional counseling for control of dental disease | No Cost |
| D1330 | Oral hygiene instructions..... | No Cost |
| D1351 | Sealant - per tooth | \$5.00 |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient - permanent tooth..... | \$5.00 |
| D1353 | Sealant repair - per tooth..... | \$3.00 |
| D1354 | Application of caries arresting medicament - per tooth - 2 per calendar year | No Cost |

SCHEDULE C

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| D1510 | Space maintainer - fixed - unilateral - per quadrant | \$15.00 |
| D1516 | Space maintainer - fixed - bilateral, maxillary | \$15.00 |
| D1517 | Space maintainer - fixed - bilateral, mandibular | \$15.00 |
| D1520 | Space maintainer - removable - unilateral - per quadrant..... | \$15.00 |
| D1526 | Space maintainer - removable - bilateral, maxillary . | \$15.00 |
| D1527 | Space maintainer - removable - bilateral, mandibular..... | \$15.00 |
| D1551 | Re-cement or re-bond bilateral space maintainer - maxillary | No Cost |
| D1552 | Re-cement or re-bond bilateral space maintainer - mandibular..... | No Cost |
| D1553 | Re-cement or re-bond unilateral space maintainer - per quadrant..... | No Cost |
| D1556 | Removal of fixed unilateral space maintainer - per quadrant..... | No Cost |
| D1557 | Removal of fixed bilateral space maintainer - maxillary | No Cost |
| D1558 | Removal of fixed bilateral space maintainer - mandibular..... | No Cost |
| D1575 | Distal shoe space maintainer - fixed, unilateral - per quadrant - child to age 9..... | \$17.00 |

D2000-D2999

III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$100.00 per crown, beyond the 6th unit.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

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| D2140 | Amalgam - one surface, primary or permanent..... | No Cost |
| D2150 | Amalgam - two surfaces, primary or permanent..... | No Cost |
| D2160 | Amalgam - three surfaces, primary or permanent .. | No Cost |
| D2161 | Amalgam - four or more surfaces, primary or permanent | No Cost |
| D2330 | Resin-based composite - one surface, anterior..... | No Cost |
| D2331 | Resin-based composite - two surfaces, anterior..... | No Cost |
| D2332 | Resin-based composite - three surfaces, anterior..... | No Cost |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | No Cost |

SCHEDULE C

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| D2390 | Resin-based composite crown, anterior | No Cost |
| D2391 | Resin-based composite - one surface, posterior | \$45.00 |
| D2392 | Resin-based composite - two surfaces, posterior ... | \$55.00 |
| D2393 | Resin-based composite - three surfaces, posterior . | \$65.00 |
| D2394 | Resin-based composite - four or more surfaces, posterior | \$75.00 |
| D2510 | Inlay - metallic - one surface | No Cost |
| D2520 | Inlay - metallic - two surfaces | No Cost |
| D2530 | Inlay - metallic - three or more surfaces | No Cost |
| D2542 | Onlay - metallic - two surfaces | No Cost |
| D2543 | Onlay - metallic - three surfaces | No Cost |
| D2544 | Onlay - metallic - four or more surfaces | No Cost |
| D2610 | Inlay - porcelain/ceramic - one surface | \$135.00 |
| D2620 | Inlay - porcelain/ceramic - two surfaces | \$150.00 |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces .. | \$160.00 |
| D2642 | Onlay - porcelain/ceramic - two surfaces | \$150.00 |
| D2643 | Onlay - porcelain/ceramic - three surfaces | \$165.00 |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces .. | \$175.00 |
| D2650 | Inlay - resin-based composite - one surface | \$85.00 |
| D2651 | Inlay - resin-based composite - two surfaces | \$95.00 |
| D2652 | Inlay - resin-based composite - three or more surfaces | \$115.00 |
| D2662 | Onlay - resin-based composite - two surfaces | \$110.00 |
| D2663 | Onlay - resin-based composite - three surfaces | \$120.00 |
| D2664 | Onlay - resin-based composite - four or more surfaces | \$145.00 |
| D2710 | Crown - resin-based composite (indirect) | \$40.00 |
| D2712 | Crown - 3/4 resin-based composite (indirect) | \$40.00 |
| D2720 | Crown - resin with high noble metal | \$160.00 |
| D2721 | Crown - resin with predominantly base metal | \$60.00 |
| D2722 | Crown - resin with noble metal | \$60.00 |
| D2740 | Crown - porcelain/ceramic | \$60.00 |
| D2750 | Crown - porcelain fused to high noble metal | \$160.00 |
| D2751 | Crown - porcelain fused to predominantly base metal | \$60.00 |
| D2752 | Crown - porcelain fused to noble metal | \$60.00 |

SCHEDULE C

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| D2753 | Crown - porcelain fused to titanium and titanium alloys | \$160.00 |
| D2780 | Crown - 3/4 cast high noble metal | \$160.00 |
| D2781 | Crown - 3/4 cast predominantly base metal | \$60.00 |
| D2782 | Crown - 3/4 cast noble metal | \$60.00 |
| D2783 | Crown - 3/4 porcelain/ceramic | \$195.00 |
| D2790 | Crown - full cast high noble metal | \$160.00 |
| D2791 | Crown - full cast predominantly base metal | \$60.00 |
| D2792 | Crown - full cast noble metal | \$60.00 |
| D2794 | Crown - titanium and titanium alloys | \$160.00 |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | No Cost |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | No Cost |
| D2920 | Re-cement or re-bond crown | No Cost |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp (anterior) | No Cost |
| D2928 | Prefabricated porcelain/ceramic crown - permanent tooth | No Cost |
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth - anterior | \$10.00 |
| D2930 | Prefabricated stainless steel crown - primary tooth | No Cost |
| D2931 | Prefabricated stainless steel crown - permanent tooth | No Cost |
| D2932 | Prefabricated resin crown - anterior primary tooth . | \$10.00 |
| D2933 | Prefabricated stainless steel crown with resin window - anterior primary tooth | \$10.00 |
| D2940 | Protective restoration | \$10.00 |
| D2941 | Interim therapeutic restoration - primary dentition . | \$10.00 |
| D2949 | Restorative foundation for an indirect restoration .. | \$10.00 |
| D2950 | Core buildup, including any pins when required | \$10.00 |
| D2951 | Pin retention - per tooth, in addition to restoration . | \$10.00 |
| D2952 | Post and core in addition to crown, indirectly fabricated - includes canal preparation | \$10.00 |
| D2953 | Each additional indirectly fabricated post - same tooth - includes canal preparation | \$10.00 |
| D2954 | Prefabricated post and core in addition to crown - base metal post; includes canal preparation | \$10.00 |

SCHEDULE C

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| D2957 | Each additional prefabricated post - same tooth - base metal post; includes canal preparation | \$10.00 |
| D2971 | Additional procedures to customize a crown to fit under an existing partial denture framework. | \$12.00 |
| D2980 | Crown repair necessitated by restorative material failure | \$10.00 |
| D2981 | Inlay repair necessitated by restorative material failure | \$10.00 |
| D2982 | Onlay repair necessitated by restorative material failure | \$10.00 |
| D2983 | Veneer repair necessitated by restorative material failure | \$10.00 |
| D2990 | Resin infiltration of incipient smooth surface lesions - limited to permanent molars | \$5.00 |
| D3000-D3999 | IV. ENDODONTICS | |
| D3110 | Pulp cap - direct (excluding final restoration) | No Cost |
| D3120 | Pulp cap - indirect (excluding final restoration) | No Cost |
| D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | No Cost |
| D3221 | Pulpal debridement, primary and permanent teeth | \$6.00 |
| D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | No Cost |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | \$6.00 |
| D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | \$6.00 |
| D3310 | Root canal - endodontic therapy, anterior tooth (excluding final restoration) | \$30.00 |
| D3320 | Root canal - endodontic therapy, premolar tooth (excluding final restoration) | \$60.00 |
| D3330 | Root canal - endodontic therapy, molar tooth (excluding final restoration) | \$90.00 |
| D3331 | Treatment of root canal obstruction; non-surgical access | \$45.00 |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | \$45.00 |
| D3333 | Internal root repair of perforation defects | \$45.00 |
| D3346 | Retreatment of previous root canal therapy - anterior | \$45.00 |

SCHEDULE C

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| D3347 | Retreatment of previous root canal therapy - premolar | \$75.00 |
| D3348 | Retreatment of previous root canal therapy - molar | \$105.00 |
| D3351 | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | \$70.00 |
| D3352 | Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | \$45.00 |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | \$45.00 |
| D3410 | Apicoectomy - anterior | \$50.00 |
| D3421 | Apicoectomy - premolar (first root) | \$50.00 |
| D3425 | Apicoectomy - molar (first root) | \$50.00 |
| D3426 | Apicoectomy (each additional root) | No Cost |
| D3430 | Retrograde filling - per root | \$50.00 |
| D3450 | Root amputation - per root (Not covered in conjunction with Procedure D3920) | No Cost |
| D3471 | Surgical repair of root resorption - anterior | \$50.00 |
| D3472 | Surgical repair of root resorption - premolar | \$50.00 |
| D3473 | Surgical repair of root resorption - molar | \$50.00 |
| D3501 | Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior | \$50.00 |
| D3502 | Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar | \$50.00 |
| D3503 | Surgical exposure of root surface without apicoectomy or repair of root resorption - molar ... | \$50.00 |
| D3920 | Hemisection (including any root removal), not including root canal therapy | No Cost |
| D3921 | Decoronation or submergence of an erupted tooth | No Cost |

SCHEDULE C

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| D4000-D4999 | V. PERIODONTICS | |
| <i>- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.</i> | | |
| D4210 | <i>Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant</i> | <i>\$75.00</i> |
| D4211 | <i>Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant</i> | <i>\$15.00</i> |
| D4212 | <i>Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth</i> | <i>\$15.00</i> |
| D4240 | <i>Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant</i> | <i>\$75.00</i> |
| D4241 | <i>Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant</i> | <i>\$75.00</i> |
| D4245 | <i>Apically positioned flap</i> | <i>\$75.00</i> |
| D4249 | <i>Clinical crown lengthening - hard tissue</i> | <i>\$75.00</i> |
| D4260 | <i>Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant</i> | <i>\$150.00</i> |
| D4261 | <i>Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant</i> | <i>\$150.00</i> |
| D4263 | <i>Bone replacement graft - retained natural tooth - first site in quadrant</i> | <i>\$195.00</i> |
| D4264 | <i>Bone replacement graft - retained natural tooth - each additional site in quadrant</i> | <i>\$60.00</i> |
| D4270 | <i>Pedicle soft tissue graft procedure</i> | <i>\$195.00</i> |
| D4274 | <i>Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)</i> | <i>\$45.00</i> |
| D4277 | <i>Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft</i> | <i>\$195.00</i> |
| D4278 | <i>Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site</i> | <i>\$100.00</i> |

SCHEDULE C

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| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant - limited to 4 quadrants during any 12 consecutive months..... | No Cost |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant - limited to 4 quadrants during any 12 consecutive months..... | No Cost |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - 1 D1110, D1120 or D4346 per 6 month period..... | No Cost |
| D4355 | Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - limited to 1 treatment in any 12 consecutive months..... | No Cost |
| D4910 | Periodontal maintenance - limited to 2 per calendar year (only covered after active therapy)..... | No Cost |
| D4910 | Additional periodontal maintenance (beyond 2 per calendar year) | \$55.00 |
| D4921 | Gingival irrigation - per quadrant..... | No Cost |

D5000-D5899

VI. PROSTHODONTICS (removable)

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

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

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

- Interim dentures are limited to initial placement of interim partial denture/stayplate to replace extracted anterior tooth during healing.

D5110 Complete denture - maxillary.....\$75.00

D5120 Complete denture - mandibular.....\$75.00

D5130 Immediate denture - maxillary.....\$90.00

D5140 Immediate denture - mandibular.....\$90.00

D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth).....\$85.00

D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth).....\$85.00

SCHEDULE C

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| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$85.00 |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$85.00 |
| D5221 | Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$90.00 |
| D5222 | Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$90.00 |
| D5223 | Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$90.00 |
| D5224 | Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$90.00 |
| D5225 | Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery ... | \$135.00 |
| D5226 | Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) | \$135.00 |
| D5227 | Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) | \$90.00 |
| D5228 | Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) | \$90.00 |
| D5410 | Adjust complete denture - maxillary | No Cost |
| D5411 | Adjust complete denture - mandibular | No Cost |
| D5421 | Adjust partial denture - maxillary | No Cost |
| D5422 | Adjust partial denture - mandibular | No Cost |
| D5511 | Repair broken complete denture base, mandibular . | \$15.00 |
| D5512 | Repair broken complete denture base, maxillary | \$15.00 |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | \$5.00 |
| D5611 | Repair resin partial denture base, mandibular | \$15.00 |
| D5612 | Repair resin partial denture base, maxillary | \$15.00 |
| D5621 | Repair cast partial framework, mandibular | \$15.00 |
| D5622 | Repair cast partial framework, maxillary | \$15.00 |

SCHEDULE C

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| D5630 | Repair or replace broken retentive/clasping materials - per tooth | \$15.00 |
| D5640 | Replace broken teeth - per tooth | \$5.00 |
| D5650 | Add tooth to existing partial denture | \$5.00 |
| D5660 | Add clasp to existing partial denture - per tooth | \$5.00 |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | \$75.00 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | \$75.00 |
| D5710 | Rebase complete maxillary denture | \$30.00 |
| D5711 | Rebase complete mandibular denture | \$30.00 |
| D5720 | Rebase maxillary partial denture | \$30.00 |
| D5721 | Rebase mandibular partial denture | \$30.00 |
| D5725 | Rebase hybrid prosthesis | \$30.00 |
| D5730 | Reline complete maxillary denture (chairside) | \$15.00 |
| D5731 | Reline complete mandibular denture (chairside) | \$15.00 |
| D5740 | Reline maxillary partial denture (chairside) | \$15.00 |
| D5741 | Reline mandibular partial denture (chairside) | \$15.00 |
| D5750 | Reline complete maxillary denture (laboratory) | \$30.00 |
| D5751 | Reline complete mandibular denture (laboratory) .. | \$30.00 |
| D5760 | Reline maxillary partial denture (laboratory) | \$30.00 |
| D5761 | Reline mandibular partial denture (laboratory) | \$30.00 |
| D5765 | Soft liner for complete or partial removable denture - indirect | \$30.00 |
| D5820 | Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary | No Cost |
| D5821 | Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular | No Cost |
| D5850 | Tissue conditioning, maxillary | No Cost |
| D5851 | Tissue conditioning, mandibular | No Cost |

SCHEDULE C

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$100.00 per crown, beyond the 6th unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

| | | |
|-------|--|----------|
| D6210 | Pontic - cast high noble metal | \$160.00 |
| D6211 | Pontic - cast predominantly base metal | \$60.00 |
| D6212 | Pontic - cast noble metal..... | \$60.00 |
| D6240 | Pontic - porcelain fused to high noble metal..... | \$160.00 |
| D6241 | Pontic - porcelain fused to predominantly base metal | \$60.00 |
| D6242 | Pontic - porcelain fused to noble metal | \$60.00 |
| D6243 | Pontic - porcelain fused to titanium and titanium alloys | \$60.00 |
| D6245 | Pontic - porcelain/ceramic..... | \$195.00 |
| D6250 | Pontic - resin with high noble metal | \$160.00 |
| D6251 | Pontic - resin with predominantly base metal..... | \$60.00 |
| D6252 | Pontic - resin with noble metal..... | \$60.00 |
| D6600 | Retainer inlay - porcelain/ceramic, two surfaces | \$150.00 |
| D6601 | Retainer inlay - porcelain/ceramic, three or more surfaces | \$160.00 |
| D6602 | Retainer inlay - cast high noble metal, two surfaces | No Cost |
| D6603 | Retainer inlay - cast high noble metal, three or more surfaces..... | No Cost |
| D6604 | Retainer inlay - cast predominantly base metal, two surfaces | No Cost |
| D6605 | Retainer inlay - cast predominantly base metal, three or more surfaces | No Cost |
| D6606 | Retainer inlay - cast noble metal, two surfaces | No Cost |
| D6607 | Retainer inlay - cast noble metal, three or more surfaces | No Cost |
| D6608 | Retainer onlay - porcelain/ceramic, two surfaces | \$150.00 |

SCHEDULE C

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| D6609 | Retainer onlay - porcelain/ceramic, three or more surfaces | \$165.00 |
| D6610 | Retainer onlay - cast high noble metal, two surfaces | No Cost |
| D6611 | Retainer onlay - cast high noble metal, three or more surfaces | No Cost |
| D6612 | Retainer onlay - cast predominantly base metal, two surfaces | No Cost |
| D6613 | Retainer onlay - cast predominantly base metal, three or more surfaces | No Cost |
| D6614 | Retainer onlay - cast noble metal, two surfaces | No Cost |
| D6615 | Retainer onlay - cast noble metal, three or more surfaces | No Cost |
| D6720 | Retainer crown - resin with high noble metal..... | \$160.00 |
| D6721 | Retainer crown - resin with predominantly base metal | \$60.00 |
| D6722 | Retainer crown - resin with noble metal | \$60.00 |
| D6740 | Retainer crown - porcelain/ceramic | \$195.00 |
| D6750 | Retainer crown - porcelain fused to high noble metal | \$160.00 |
| D6751 | Retainer crown - porcelain fused to predominantly base metal..... | \$60.00 |
| D6752 | Retainer crown - porcelain fused to noble metal | \$60.00 |
| D6753 | Retainer crown - porcelain fused to titanium and titanium alloys..... | \$160.00 |
| D6780 | Retainer crown - 3/4 cast high noble metal..... | \$160.00 |
| D6781 | Retainer crown - 3/4 cast predominantly base metal | \$60.00 |
| D6782 | Retainer crown - 3/4 cast noble metal | \$60.00 |
| D6783 | Retainer crown - 3/4 porcelain/ceramic..... | \$195.00 |
| D6784 | Retainer crown - titanium and titanium alloys..... | \$160.00 |
| D6790 | Retainer crown - full cast high noble metal | \$160.00 |
| D6791 | Retainer crown - full cast predominantly base metal | \$60.00 |
| D6792 | Retainer crown - full cast noble metal..... | \$60.00 |
| D6930 | Re-cement or re-bond fixed partial denture..... | No Cost |
| D6940 | Stress breaker | No Cost |
| D6980 | Fixed partial denture repair necessitated by restorative material failure..... | \$15.00 |

SCHEDULE C

D7000-D7999

X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

- Extractions solely for orthodontic purposes are not covered.

| | | |
|-------|---|---------|
| D7111 | Extraction, coronal remnants - primary tooth | No Cost |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | No Cost |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | No Cost |
| D7220 | Removal of impacted tooth - soft tissue | No Cost |
| D7230 | Removal of impacted tooth - partially bony | \$30.00 |
| D7240 | Removal of impacted tooth - completely bony | \$40.00 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications..... | \$40.00 |
| D7250 | Removal of residual tooth roots (cutting procedure)..... | No Cost |
| D7251 | Coronectomy - intentional partial tooth removal | No Cost |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth..... | \$50.00 |
| D7280 | Exposure of an unerupted tooth | \$85.00 |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | \$85.00 |
| D7283 | Placement of device to facilitate eruption of impacted tooth..... | No Cost |
| D7286 | Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures | No Cost |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$30.00 |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$30.00 |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant..... | \$40.00 |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant..... | \$40.00 |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | No Cost |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm..... | No Cost |
| D7471 | Removal of lateral exostosis (maxilla or mandible) . | No Cost |

SCHEDULE C

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| D7472 | Removal of torus palatinus | No Cost |
| D7473 | Removal of torus mandibularis | No Cost |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | No Cost |
| D7922 | Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site | No Cost |
| D7961 | Buccal/labial frenectomy (frenulectomy) | No Cost |
| D7962 | Lingual frenectomy (frenulectomy) | No Cost |
| D7970 | Excision of hyperplastic tissue - per arch | \$50.00 |
| D7971 | Excision of pericoronal gingiva | \$50.00 |

D8000-D8999

XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.
- In addition to the codes listed below, Pre and post orthodontic records may include any of the Intraoral, Extraoral or Bitewing codes listed in the Diagnostic section.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes:.....\$300.00

| | |
|-------|---|
| D0210 | Intraoral - complete series of radiographic images |
| D0251 | Extraoral posterior dental radiographic image |
| D0322 | Tomographic survey |
| D0330 | Panoramic radiographic image |
| D0340 | 2D cephalometric radiographic image - acquisition, measurement and analysis |
| D0350 | 2D oral/facial photographic images obtained intraorally or extraorally |
| D0351 | 3D photographic image |
| D0470 | Diagnostic casts |

The benefit for post-treatment records includes:.....\$120.00

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| D0210 | Intraoral - complete series of radiographic images |
| D0470 | Diagnostic casts |

SCHEDULE C

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| D8010 | Limited orthodontic treatment of the primary dentition | \$230.00 |
| D8020 | Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19 | \$230.00 |
| D8030 | Limited orthodontic treatment of the adolescent dentition - adolescent to age 19 | \$230.00 |
| D8040 | Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children | \$430.00 |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 | \$490.00 |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19 | \$490.00 |
| D8090 | Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adult children | \$490.00 |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development (Enrollee pays a \$25.00 fee if orthodontic treatment is not required or is declined by the Enrollee)..... | No Cost |
| D8670 | Periodic orthodontic treatment visit (Charge per month for 24 months) | \$40.00 |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of removable retainers)..... | No Cost |
| D8681 | Removable orthodontic retainer adjustment..... | No Cost |
| D8999 | Unspecified orthodontic procedure, by report - includes treatment planning session | \$200.00 |
| D9000-D9999 | XII. ADJUNCTIVE GENERAL SERVICES | |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | \$5.00 |
| D9211 | Regional block anesthesia | No Cost |
| D9212 | Trigeminal division block anesthesia | No Cost |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures..... | No Cost |
| D9219 | Evaluation for moderate sedation, deep sedation or general anesthesia..... | No Cost |
| D9222 | Deep sedation/general anesthesia - first 15 minutes | \$83.00 |

SCHEDULE C

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|-------|---|----------|
| D9223 | Deep sedation/general anesthesia - each subsequent 15 minute increment..... | \$83.00 |
| D9239 | Intravenous moderate (conscious) sedation/analgesia - first 15 minutes..... | \$83.00 |
| D9243 | Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment..... | \$83.00 |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician..... | No Cost |
| D9311 | Consultation with a medical health care professional..... | No Cost |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | \$5.00 |
| D9440 | Office visit - after regularly scheduled hours..... | \$20.00 |
| D9450 | Case presentation, detailed and extensive treatment planning..... | No Cost |
| D9912 | Pre-visit patient screening | \$0.00 |
| D9932 | Cleaning and inspection of removable complete denture, maxillary | No Cost |
| D9933 | Cleaning and inspection of removable complete denture, mandibular..... | No Cost |
| D9934 | Cleaning and inspection of removable partial denture, maxillary | No Cost |
| D9935 | Cleaning and inspection of removable partial denture, mandibular..... | No Cost |
| D9943 | Occlusal guard adjustment..... | \$10.00 |
| D9944 | Occlusal guard - hard appliance, full arch - limited to 1 D9944, D9945 or D9946 in 24 months..... | \$95.00 |
| D9945 | Occlusal guard - soft appliance, full arch - limited to 1 D9944, D9945 or D9946 in 24 months..... | \$95.00 |
| D9946 | Occlusal guard - hard appliance, partial arch - limited to 1 D9944, D9945 or D9946 in 24 months . | \$95.00 |
| D9951 | Occlusal adjustment, limited..... | \$20.00 |
| D9952 | Occlusal adjustment, complete..... | \$40.00 |
| D9975 | External bleaching for home application, per arch; includes materials and fabrication of custom trays - limited to one bleaching tray and gel for two weeks of self-treatment | \$125.00 |
| D9986 | Missed appointment - without 24 hour notice | \$10.00 |
| D9987 | Canceled appointment - without 24 hour notice..... | \$10.00 |

SCHEDULE C

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| D9990 | Certified translation or sign-language services - per visit..... | No Cost |
| D9991 | Dental case management - addressing appointment compliance barriers | No Cost |
| D9992 | Dental case management - care coordination | No Cost |
| D9995 | Teledentistry - synchronous; real-time encounter | No Cost |
| D9996 | Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review..... | No Cost |
| D9997 | Dental case management - Patients with special Health Care Needs | No Cost |

Procedures with age restrictions will be subject to exceptions based on medical necessity.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Us. The Enrollee pays the Copayment specified for such services.

SCHEDULE C

SCHEDULE B

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations of Benefits

- 1. The frequency of certain Benefits is limited. All frequency limitations are listed in Schedule A, Description of Benefits and Copayments. (Frequency limitations on diagnostic and preventive procedures do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist).*
- 2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.*
- 3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by an oral surgeon for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241);*
- 4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.*
- 5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's standard fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.*
- 6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.*

SCHEDULE C

Exclusions of Benefits

1. *Any procedure that is not specifically listed under Schedule A, Description of Benefits and Copayments.*
2. *Any procedure that in the professional opinion of the Contract Dentist:*
 - a. *has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or*
 - b. *is inconsistent with generally accepted standards for dentistry.*
3. *Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.*
4. *Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).*
5. *Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).*
6. *Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.*
7. *Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.*
8. *Consultations for non-covered Benefits.*
9. *Dental services received from any dental facility other than a Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for Emergency Services as described in the Contract and/or Evidence of Coverage.*
10. *All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.*
11. *Prescription drugs.*

SCHEDULE C

12. *Dental expenses incurred in connection with any dental or orthodontic procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.*
13. *Lost, stolen or broken orthodontic appliances.*
14. *Changes in orthodontic treatment necessitated by accident of any kind.*
15. *Myofunctional and parafunctional appliances and/or therapies.*
16. *Composite or ceramic brackets, lingual adaptation of orthodontic bands.*
17. *Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.*
18. *Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.*
19. *The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.*

SCHEDULE D

DELTA DENTAL OF CALIFORNIA
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

MULTI-STATE RIDER to
DELTACARE® USA GROUP DENTAL SERVICE CONTRACT
(AFFILIATED DENTAL PLANS)

Issued to San Bernadino County ("Contractholder")

Delta Dental of California ("Delta Dental") has entered into a DeltaCare USA Group Dental Service Contract ("Contract") with the Contractholder in California, to make dental benefits available for all eligible employees of the Contractholder and their eligible dependents residing there. Contractholder also has employees in the states named below who are eligible for benefits, and who wish to obtain dental benefits offered by Contractholder. In order to provide dental benefits to enrolled eligible employees ("primary enrollees") and their eligible dependents, collectively hereinafter referred to as "enrollees", a DeltaCare USA Group Dental Service Contract will be issued to Contractholder in each of those states by the Affiliate of Delta Dental listed in the attached Table of Affiliates. Such Affiliate Contracts shall bind the Affiliate and the Contractholder upon execution of the Contract with Delta Dental. The Contract issued to Contractholder by each Affiliate may be inspected by Contractholder prior to executing the Contract with Delta Dental and will be provided to Contractholder upon written request.

Benefits: The benefits which will be provided by each Affiliate are shown in the evidence of coverage or other document which the Affiliate will deliver to each primary enrollee who resides in the state(s) for whose residents it has undertaken to provide benefits. A copy of each such evidence of coverage or other document is attached to, and shall form a part of, this Rider. Due to state-specific regulatory requirements, it may not be possible for Affiliates to provide benefits which exactly duplicate those in the Contract; however, Affiliates agree to provide benefits which most closely approximate those benefits in the Contract.

Affiliate Addendum: In the event an Affiliate is subject to state-specific legal requirements that affect the Contract and/or the Contractholder, the affected provisions of the Contract are stipulated in an Affiliate Addendum ("Addendum") which are attached to, and form a part of, this Rider. Provisions included in the Addendum will not duplicate those in the evidence of coverage or other document noted above. The terms of the Affiliate Contract and Affiliate Addendum shall take precedence over any similar terms contained in the Contract issued to Contractholder by Delta Dental with respect to coverage of enrollees in a particular state. A full copy of the DeltaCare USA Group Dental Service Contract issued to the Contractholder by any Affiliate will be made available to Contractholder upon written request to:

Delta Dental of California
Attn: Contracts, Mail Stop 12th Fl
560 Mission Street, Suite 1300
San Francisco, CA 94105

Premiums: Contractholder agrees to pay premiums on behalf of enrollees in accordance with the Contract. Contractholder shall remit a single check as described in Group Variables and Premiums Schedule(s) of this Rider along with a list of all enrollees grouped according to the states in which they reside.

Effective Date: This Rider shall take effect as of the Effective Date set forth below, and shall remain in effect as long as the Contract issued by Delta Dental remains in effect, subject to other termination provisions set forth in an Affiliate Addendum for a specific state.

This Rider is hereby attached to, and shall form a part of, the Contract identified by the contract number below.

SCHEDULE D

Effective Date: July 30, 2022

Contract Number: 78852

Plan: D90

State(s): Arizona, Florida, Georgia, Idaho, Nevada, Oregon,

IN WITNESS WHEREOF, the parties have caused this Rider to be executed on the dates indicated below.

JUL 26 2022

(Date)

78852

(Group Number)

San Bernardino County

(Contractholder)

By: 

(Authorized Signature)

Curt Hagman, Chairman, Board of Supervisors

(Title)

Date: Wednesday, July 20, 2022

DELTA DENTAL OF CALIFORNIA:
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90702



Thomas J. Leibowitz, FSA, MAAA
Group Vice President and Chief Actuary



Mohammadreza Navid
Group Vice President, Sales

SCHEDULE D

MULTI-STATE RIDER to DELTACARE USA GROUP DENTAL SERVICE CONTRACT (AFFILIATED DENTAL PLANS)

GROUP VARIABLES AND PREMIUMS SCHEDULE

- A. Client Name: San Bernardino County
- B. Group Number: 78852
- C. Effective Date: July 30, 2022
- D. Contract Term: 60 Months
- E. Eligible Present Employees: As defined by the Contractholder.
Eligible New Employees: As defined by the Contractholder.
- F. Premiums per Biweekly/Monthly:
Plan Type: D90

Rates:

Contract Term: 07/30/2022 – 07/25/2025

Biweekly

| | |
|--|----------|
| Primary Enrollee: | \$ 8.44 |
| Primary Enrollee Plus One Dependent Enrollee: | \$ 14.50 |
| Primary Enrollee Plus Two or More Dependent Enrollees: | \$ 19.33 |

Monthly

| | |
|--|----------|
| Primary Enrollee: | \$ 18.28 |
| Primary Enrollee Plus One Dependent Enrollee: | \$ 31.41 |
| Primary Enrollee Plus Two or More Dependent Enrollees: | \$ 41.89 |

Not to Exceed Rates:

Contract Term: 07/26/2025 – 07/23/2027

Biweekly

| | |
|--|----------|
| Primary Enrollee: | \$ 8.69 |
| Primary Enrollee Plus One Dependent Enrollee: | \$ 14.94 |
| Primary Enrollee Plus Two or More Dependent Enrollees: | \$ 19.91 |

Monthly

| | |
|--|----------|
| Primary Enrollee: | \$ 18.83 |
| Primary Enrollee Plus One Dependent Enrollee: | \$ 32.35 |
| Primary Enrollee Plus Two or More Dependent Enrollees: | \$ 43.15 |

SCHEDULE D

- G. Remit Premium Payment to: Attn: Accounts Receivable
Delta Dental Insurance Company
P.O. Box 647006
Dallas, TX 75264-7006

SCHEDULE D

MULTI-STATE RIDER to DELTACARE USA GROUP DENTAL SERVICE CONTRACT (AFFILIATED DENTAL PLANS)

TABLE OF AFFILIATES

| <u>AFFILIATE</u> | <u>STATE(S) IN WHICH BENEFITS WILL BE PROVIDED</u> |
|--|--|
| ALPHA DENTAL OF ARIZONA, INC. 2910 N 44th Street, Suite 210 Phoenix, AZ 85018 | AZ |
| ALPHA DENTAL OF NEVADA, INC. (a Nevada Corporation) 3012 W. Charleston Blvd., Suite 120 Las Vegas, NV 89102 | NV |
| ALPHA DENTAL PROGRAMS, INC. 1701 Shoal Creek, Suite 240 Highland Village, TX 75077 | ID |
| DELTA DENTAL INSURANCE COMPANY 1130 Sanctuary Parkway Alpharetta, GA 30009 | FL, GA |
| DENTEGRA INSURANCE COMPANY 560 Mission Street, Suite 1300 San Francisco, CA 94105 | OR |

SCHEDULE D

AFFILIATE ADDENDUM
AFFILIATE: ALPHA DENTAL OF ARIZONA, INC. ("ALPHA")
STATE: ARIZONA

The attached Arizona Evidence of Coverage addresses all state-specific legal requirements.

SCHEDULE D

AFFILIATE ADDENDUM
AFFILIATE: DELTA DENTAL INSURANCE COMPANY ("Delta Dental")
STATE: FLORIDA

The provisions outlined below apply only to coverage provided for Contractholder's enrollees in the state of Florida:

- (1) Florida premiums may change with 60 days written notice whenever the terms of the Florida contract are changed by amendment or a change in Delta Dental's liability because of law or regulation.
- (2) In the event that Delta Dental shall desire to change Florida premiums or benefits effective at the end of any contract term, advice of such changes will be given to Contractholder upon at least 60 days written notice.
- (3) Florida premiums are subject to a premium payment grace period of 30 days. If premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, coverage for Florida enrollees will stay in force.
- (4) The Florida contract may be terminated by Delta Dental if Contractholder fails to furnish Delta Dental with the names of eligible enrollees or pay premium in the amount and manner required by the contract, provided Contractholder has been notified of such failure and, except for non-payment of premium, at least 45 days have elapsed since the notification.
- (5) Delta Dental may terminate the Florida contract upon 60 days written notice in the event the minimum enrollment of five primary enrollees is not maintained in three consecutive months at any time during a contract term.
- (6) If either Delta Dental or the Contractholder desires to terminate the Florida contract at the end of a contract term, the other party must be given 60 days advance written notice. If the termination is initiated by Delta Dental, it will be without prejudice to any continuous loss which began while the contract was in force.
- (7) In the absence of fraud, all statements made by the Contractholder or enrollee will be deemed representations and not warranties. No such statement will be used in defense of a claim under the Florida contract unless it is included in the written instrument signed by the Contractholder or enrollee and a copy of that instrument has been furnished to the Contractholder or enrollee.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- (8) The Florida contract does not replace or affect any requirements for coverage by Worker's Compensation Insurance.
- (9) Contractholder and Delta Dental will permit and encourage the professional relationship between dentist and patient to be maintained without interference.

SCHEDULE D

AFFILIATE ADDENDUM
AFFILIATE: DELTA DENTAL INSURANCE COMPANY ("Delta Dental")
STATE: GEORGIA

The provisions outlined below apply only to coverage provided for Contractholder's enrollees in the state of Georgia:

- (1) Georgia premiums may change with 60 days written notice whenever the terms of the Georgia contract are changed by amendment or a change in Delta Dental's liability because of law or regulation.
- (2) In the event that Delta Dental shall desire to change Georgia premiums or benefits effective at the end of any contract term, advice of such changes will be given to Contractholder upon at least 60 days written notice.
- (3) Georgia premiums are subject to a premium payment grace period of 31 days. If premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, coverage for Georgia enrollees will stay in force and Contractholder will remain responsible for premiums incurred during this period.
- (4) Delta Dental may terminate the Georgia contract upon 60 days written notice in the event the minimum enrollment of five primary enrollees is not maintained in three consecutive months at any time during a contract term.
- (5) If either Delta Dental or the Contractholder desires to terminate the Georgia contract at the end of the contract term, the other party must be given 60 days advance written notice.
- (6) In the absence of fraud, all statements made by the Contractholder or enrollee will be deemed representations and not warranties. No such statement will be used in defense of a claim under the Georgia contract unless it is included in the written instrument signed by the Contractholder or enrollee and a copy of that instrument has been furnished to the Contractholder or enrollee.
- (7) The Georgia contract does not replace or affect any requirements for coverage by Worker's Compensation Insurance.

SCHEDULE D

AFFILIATE ADDENDUM
AFFILIATE: ALPHA DENTAL PROGRAMS, INC. ("ALPHA")
STATE: IDAHO

1. After payment of the initial premium, Contractholder shall have a grace period of 31 days for the payment of any subsequent Premium due, during which this Contract shall remain in force. ALPHA will furnish Benefits during a grace period and Contractholder shall remain responsible for Premiums incurred during this period.
2. THIS CONTRACT PROVIDES LIMITED BENEFITS FOR TREATMENT FROM A NON-PARTICIPATING DENTIST.
3. After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the Contractholder in the application for such policy shall be used to void the policy or to deny a claim for loss incurred. The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period.
4. This Contract may be terminated by ALPHA upon Contractholder's failure (i) to furnish ALPHA with the names of eligible Enrollees as required by Article 2, or (ii) to pay Premiums before the expiration of the 31-day grace period in the amount and manner required by Article 3, provided Contractholder has been notified of such failure and at least 15 days have elapsed since such notification.
5. Acceptance by ALPHA of the proper Premiums after termination of this Contract and without requiring a new application, shall reinstate this Contract as though it had never terminated, unless ALPHA shall, within 20 business days of receipt of such payment, either 1) refuse the payment so made, or 2) issue to Contractholder a new Contract accompanied by written notice stating clearly those respects in which the new Contract differs from this terminated Contract in Benefits, coverage or otherwise. Any Premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

SCHEDULE D

AFFILIATE ADDENDUM
AFFILIATE: ALPHA DENTAL OF NEVADA, INC. ("ALPHA")
STATE: NEVADA

The provisions outlined below apply only to coverage provided for Contractholder's enrollees in the state of Nevada:

- (1) In the event the Nevada contract replaces any discontinued policy or coverage for dental care within 60 days after the date on which the previous policy or coverage was discontinued, all persons who were covered under the previous policy or coverage on the date it was discontinued remain eligible for coverage under this contract.
- (2) Notwithstanding any other provision of the Nevada contract, in the event the Nevada contract replaces any discontinued policy or coverage for dental care within 60 days after the date on which the previous policy or coverage was discontinued, benefits provided under this contract shall be at least as extensive as the benefits provided by the previous policy or coverage, except that benefits under this contract may be reduced or excluded to the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage; provided, however, benefits of the previous policy or coverage may be reduced if notice of the reduction is given by Contractholder to persons covered under the previous policy or coverage at least 10 days before the change in benefits or insurers and in a manner which ensures that the information is received.
- (3) If during a contract term, any new tax is imposed on ALPHA by any government agency on the amount of premiums payable under the Nevada contract or the number of persons covered, or if the rate of an existing tax on the amount of premiums or the number of persons covered is increased, the Nevada premiums may be increased by the amount of any such new tax or increased taxes upon 60 days written notice.
- (4) In the event that ALPHA shall desire to change Nevada premiums or benefits effective at the end of any contract term, advice of such changes will be given to Contractholder upon at least 60 days written notice.
- (5) The Nevada contract may be terminated by ALPHA if Contractholder fails to furnish ALPHA with the names of eligible enrollees or pay premium in the amount and manner required by the contract, provided Contractholder has been notified of such failure and at least 30 days have elapsed since the notification.
- (6) ALPHA may terminate the Nevada contract upon 60 days written notice in the event the minimum enrollment of five primary enrollees is not maintained in three consecutive months at any time during a contract term.
- (7) If either ALPHA or the Contractholder desires to terminate the Nevada contract at the end of a contract term, the other party must be given 60 days advance written notice.
- (8) Acceptance by ALPHA of the proper premiums after termination of the Nevada contract and without requiring a new application, shall reinstate the contract as though it had never terminated, unless ALPHA shall within five business days of receipt of such payment, either (1) refuse the payment so made, or (2) issue to Contractholder a new contract accompanied by written notice stating clearly those respects in which the new contract differs from the terminated contract in benefits, coverage or otherwise.

SCHEDULE D

AFFILIATE ADDENDUM
AFFILIATE: DENTEGRA INSURANCE COMPANY ("Dentegra")
STATE: OREGON

The provisions outlined below apply only to coverage provided for Contractholder's enrollees in the state of Oregon:

- (1) In the absence of fraud, all statements made by Contractholders, the policyholder or an insured person shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the person.



Delta Dental Performance Guarantees

Client: San Bernardino County / 78852

Effective: 7/30/2022 – 7/23/2027

Delta Dental agrees to provide the following levels of service in the performance of its obligations under this contract. Should any of the following service levels not be met, any payment due will be issued in the form of a check, based on the total administration at the end of each contract period. Measurement, reporting, and payment of each guarantee will be on a global basis and reported annually unless stated otherwise.

| Account Management | Amount at Risk |
|---|----------------|
| A sales account executive and account manager will be assigned as contacts for the San Bernardino County to: | |
| Successfully oversee all implementation activities. | 1.5% |
| Return phone calls from San Bernardino County primary contacts within 24 hours. | 1.5% |
| Measurement will be on a client-specific basis and reported annually. | |
| Eligibility | Amount at Risk |
| 97% or higher - Electronic eligibility changes are made within 2 business days from receipt of data. Guarantee is contingent upon receipt of data in a mutually agreed upon format and system availability. | 1% |
| Measurement will be on a global basis and reported annually. | |
| Claims Turnaround | Amount at Risk |
| 90% of specialty claims will be processed within 15 calendar days and 99% of specialty claims will be processed within 30 calendar days. | |
| Claims turnaround is measured from the date of the initial receipt of the claim with complete information to the date the claim is originally processed. | 1% |
| Measurement will be on a global basis and reported annually. | |

SCHEDULE E



| Overall Claims Accuracy | Amount at Risk |
|--|----------------|
| <p>96% or higher – Specialty claims are to be processed without error; error does not have to have financial impact.</p> <p>Measurement over the course of a contract year. Measurement will be on a global basis and reported annually.</p> | 1% |
| <p>99% or higher – Specialty Claims processed will be free from financial error. (Financial Accuracy)</p> <p>Measurement over the course of a contract year. Measurement will be on a global basis and reported annually.</p> | 1% |
| Customer Service | Amount at Risk |
| <p>85% of all customer calls to the Contact Center will be answered within 30 seconds or less on average.</p> <p>Measurement over the course of a contract year. Measurement will be on a client-specific basis and reported annually.</p> | 1% |
| <p>Customer calls to the Customer Service Department will be answered within 30 seconds or less on average.</p> <p>Measurement over the course of a contract year. Measurement will be on a client-specific basis and reported annually.</p> | 1% |
| <p>Call abandonment rate will be 5% or less.</p> <p>Measurement over the course of a contract year. Measurement will be on a client-specific basis and reported annually.</p> | 1% |

SCHEDULE E



| Contract | Amount at Risk |
|---|----------------|
| Renewal notification and contractual amendments delivered to the County by April 1st of each year specified in the contract term. | 1.5% |
| Measurement will be on a client-specific basis and reported annually. | |
| Quality Management | Amount at Risk |
| A written response will be provided that acknowledges receipt of the grievance within five (5) calendar days for 95% of enrollees filing a grievance. | 1.5% |
| Measurement will be on a global basis and reported annually. | |
| Customer Satisfaction | Amount at Risk |
| 85% or higher - Customer satisfaction with their network provider. | 1% |
| Measurement over the course of a contract year. Measurement will be on a global basis and reported annually. | |
| 85% or higher - Customer satisfaction rate with Delta Dental. | 1% |
| Measurement over the course of a contract year. Measurement will be on a global basis and reported annually. | |
| Network Stability | Amount at Risk |
| Annual turnover of contracted providers will be less than 10%. | 1.5% |
| Measurement will be on a client-specific basis and reported annually. | |
| Group Report | Amount at Risk |
| Delta Dental will provide annual County-specific fee/premium/claims experience reporting and other reports as agree upon (within 30 days of the close of the established reporting period). | 1.5% |
| Measurement will be on a client-specific basis and reported annually. | |
| ID Cards | Amount at Risk |
| 90% or higher - ID cards will be distributed within 10 business days of receipt of eligibility. Measurement will be on a global basis and reported annually. | 1% |
| | |
| TOTAL ADMINISTRATION AT RISK | 19% |

Unless specified above, the length of the Performance Guarantee period will follow the term of the sold contract period.

SCHEDULE E



* Performance Guarantees apply to Fee-for-Service Plans only; excludes assessments, taxes and commissions, if applicable. Delta Dental will not incur penalties for its failure to meet the terms of these guarantees if this failure is caused by fires, acts of public enemies, acts of God, epidemics, pandemics, civil disturbances, labor disputes or by any similar act or event beyond the reasonable control of the client or Delta Dental.



HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

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

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

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

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

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

PERMITTED USES AND DISCLOSURES OF YOUR PHI

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

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

SCHEDULE F

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

Permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with the law, and when otherwise required by law. We may disclose your PHI without your prior authorization in response to the following:

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

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

Disclosures made with your authorization

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

YOUR RIGHTS REGARDING PHI

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

You may access your PHI by providing a written request. Your request must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting.

SCHEDULE F

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We will only maintain PHI that we obtain or utilize in providing your health care benefits. We may not maintain some PHI, such as treatment records or x-rays after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that we do not possess.

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

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

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

You have the right to correct or update your PHI.

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

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

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

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

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

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

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information

SCHEDULE F

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

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

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

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

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

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

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

COMPLAINTS

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

CONTACTS

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

SCHEDULE G

DELTA DENTAL DHMO COMMITMENTS TO SAN BERNARDINO COUNTY

DeltaCare USA Patient Satisfaction Survey (annual)*

*No additional cost

SCHEDULE H

REPORTS

DHMO

Utilization – which includes the following annual summaries:

- Client Occurrence Profile
- Client Occurrence Profile by Category
- Client Utilization Rate
- Top 10 Procedures
- DHMO Grievance Report (quarterly)