Delta Dental of Pennsylvania

EVIDENCE OF COVERAGE

UNIVERSITY OF MARYLAND – STUDENT PLAN

Group No: 22907

Effective Date: August 1, 2024

Underwritten and administered by:
Delta Dental of Pennsylvania
300 Corporate Center Drive, Suite 600
Camp Hill, PA 17011

In Maryland, Delta Dental PPO™ is underwritten by Delta Dental of Pennsylvania, a not-for-profit dental service company.

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Attachments: (The following documents are attached to this *EOC* and incorporated by reference into the Contract.)

Attachment A: Deductibles, Maximums and Contract Benefit Levels

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Internal Appeal and Grievance Process Addendum

Introduction

This *Evidence of Coverage* ("*EOC*") provides information about Your Delta Dental PPO™ Plan ("Plan") provided by Delta Dental of Pennsylvania ("Company"), on behalf of itself, and its affiliated companies. To offer these Benefits, the Contractholder has entered into a Group Dental Insurance Contract with Us.

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

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

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

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

Contact Us
For more information, visit Our website at deltadentalins.com or call Our Customer Service Center at 800-932-0783 or You may submit an inquiry to:

Delta Dental of Pennsylvania
P.O. Box 2105
Mechanicsburg, PA 17055

Michael G. Hankinson, Esq.
Executive Vice President and Chief Legal Officer

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 Your dental coverage works.

Benefits: covered dental services as described under the Contract, this *EOC*, *Attachments A and B* and any other attachments.

Coinsurance: the amount You are responsible for paying as shown in *Attachment A*.

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

Contract Benefit Level: the percentage of the Maximum Allowance We will pay after any applicable Deductible has been satisfied as shown in *Attachment A*.

Contractholder: the organization named herein contracting with Us to obtain dental Benefits.

Contract Term: the period during which coverage is in effect whether on a Calendar Year or Contract Year basis.

Contract Year: the 12-month period starting on the Effective Date and each subsequent 12-month period thereafter.

Deductible: a dollar amount that You must pay for certain covered services before We pay.

Delta Dental PPO™ Dentist ("PPO Dentist"): a PPO Dentist agrees to accept the PPO Maximum Allowance as payment in full for covered Benefits and to adhere to Our administrative guidelines. You will enjoy the lowest out-of-pocket costs when obtaining treatment from a PPO Dentist.

Delta Dental Premier® Dentist ("Premier Dentist"): a Premier Dentist agrees to accept the Premier Maximum Allowance as payment in full for covered Benefits and to adhere to Our administrative guidelines. These Dentists have not agreed to accept the PPO Maximum Allowance as payment in full. As a result, You often experience higher out-of-pocket costs.

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

Dependent ("Dependent Enrollee"): the Primary Enrollee's Dependent and any individual eligible to enroll for Benefits because of their relationship with the Primary Enrollee. And includes:

- the Spouse;
- Dependent children from birth to age 26.

Children include natural children, stepchildren, foster children, grandchildren, adopted children, children placed for adoption, children to receive benefits required by court order, and children of a partner as recognized by the Contractholder.

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

Enrollee ("Primary Enrollee"): student or a Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Grace Period: a period of no less than 30 days will be allowed for the payment of each Premium after the first Premium, unless We do not intend to renew the Contract beyond the period for which Premium has been accepted and notice of Our intention not to renew is delivered to the Contractholder at least 45 days before the Premium is due. The Contract will continue in force during this period.

Maximum Contract Allowance ("Maximum Allowance"): the reimbursement under Your Plan against which We calculate Our payment and Your financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Allowance for services provided:

- by a PPO Dentist is the lesser of the Dentist's Submitted Fee or the PPO Maximum Allowance.
- by a Premier Dentist is the lesser of the Dentist's Submitted Fee or the PPO Maximum Allowance for a PPO Dentist in the same geographic area.
- by a Non-Delta Dental Dentist is the lesser of the Dentist's Submitted Fee or the PPO Maximum Allowance for a PPO Dentist in the same geographic area.

Non-Delta Dental Dentist or Non-participating Dentist ("Non-Delta Dental Dentist"): a Dentist who has not signed a contract with Us to provide Benefits as a PPO Dentist or Premier Dentist and does not adhere to Our administrative guidelines. These Dentists may balance bill up to their Submitted Fee.

Open Enrollment Period: the period the Contractholder has established for You to make changes in coverage selections for the next Contract Term.

Optional Services: services that are more expensive than the form of treatment provided under accepted dental practice standards. Optional Services also include the use of specialized techniques instead of standard procedures.

Plan: dental Benefits selected by the Contractholder and provided under the Contract, *EOC* and any attachments.

PPO Maximum Contract Allowance ("PPO Maximum Allowance"): the maximum fee for a covered service payable by Us to a PPO Dentist.

Premier Maximum Contract Allowance ("Premier Maximum Allowance"): the maximum fee for a covered service payable by Us to a Premier Dentist.

Premium: the amount the Contractholder or You, if applicable, pay for coverage and as stated in the *Group Information* section of the Contract.

Pre-Treatment Estimate: an estimation of the allowable Benefits for the services proposed, it is not a guarantee of payment. Refer to the Pre-Treatment Estimate section for additional information.

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

Spouse: an individual who is a partner of the Primary Enrollee as:

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

Submitted Fee: the amount the Dentist bills and submits for a specific procedure.

Eligibility and Enrollment – When Coverage Begins

Eligibility Requirements

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported. You are eligible to enroll if You meet the eligibility requirements defined by the Contractholder as specified in this EOC. See Your Human Resources Department or website for complete information.

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

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

Medicare eligibility will not affect Your eligibility or Your Dependent's eligibility, if applicable.

Overage Children
An overage unmarried Dependent child may be eligible if:

- The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
- The child is chiefly dependent on the Enrollee for support; and
- Proof of disability is provided within 31 days of request. Proof of disability will not be required more than one (1) time per year following a two-year period after the Dependent reaches the limiting age. Eligibility will continue as long as the Dependent relies on the Enrollee for support because of a physically or mentally disabling injury, illness or condition that began before the Dependent reached the limiting age.

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

If You are responsible for Your Premium,

- You must enroll within 31 days after the date You become eligible or during an Open Enrollment Period.
- All Dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period or *Special Enrollment Period*.
- If You elect Dependent coverage, You must enroll all Your Dependent Enrollees for coverage.

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

A Dependent may not be enrolled under more than one (1) Primary Enrollee.

A child who is eligible as a Primary Enrollee and a Dependent Enrollee can be insured as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

If You are eligible for family members' coverage and are required by court or administrative order to furnish coverage for Your Dependent child, that child will be entitled to coverage regardless of enrollment period restrictions. If You do not elect coverage for Your Dependent child, the non-insuring parent, child support enforcement agency, or Maryland Department of Health will be allowed to apply for enrollment on behalf of the child regardless of enrollment period restrictions. This coverage will remain in effect unless written evidence is provided to Us that:

- The order is no longer in effect;
- The child has been or will be enrolled under other dental insurance coverage that will take effect on or before the effective date of termination;
- The Contractholder has eliminated family members' coverage for all employees; or
- You are no longer eligible, except that You may then elect continuation coverage under COBRA for the child, if applicable.

If an eligible Dependent child has coverage through an insuring parent, We will provide to the non-insuring parent membership cards, claims forms, and any other information necessary for the child to obtain Benefits through the dental insurance coverage; and process the claims forms and make appropriate payment to the non-insuring parent, provider, or Maryland Department of Health if the non-insuring parent incurs expenses for dental care provided to the child.

Special Enrollment Periods – Enrollment Changes
After Your Effective Date, You may change Your enrollment during an Open Enrollment Period or during a *Special Enrollment Period* as a result of a qualifying status change. Qualifying status changes include, but are not limited to, the following events:

- Marital status Examples include, but are not limited to: marriage, divorce, legal separation, annulment or death;
- Number of Dependents (a child's birth, adoption of a child, placement of child for adoption, child to receive benefits required by court order, addition of a grandchild, stepchild or foster child or death of a child);
- Dependent child ceases to satisfy eligibility requirements;
- Employment status (change in Your or Your Dependent's employment status);
- Residence (You move);
- Court order requiring Dependent coverage;
- Loss of other group coverage;
- Any other current or future election changes permitted by Internal Revenue Code Section 125.

Continuation of Benefits
We will not pay for any services/treatment received after Your coverage ends. However, We will extend Benefits for at least 90 days after the date on which Your coverage ends or until the services are complete if the treatment:

- began before the date coverage terminates; and
- requires two (2) or more visits on separate days to a Dentist's office.

In the case of orthodontic procedures, notwithstanding any other limitation on orthodontic Benefits, We will extend Benefits:

- for 60 days if the orthodontist has agreed to or is receiving monthly payments; or
- for 60 days or until the end of the quarter in progress, whichever is longer, if the orthodontist has agreed to or is receiving quarterly payments.

Premiums

Subject to the terms and conditions of the Contract, We agree to provide the Benefits described in this *EOC* in consideration of the Contractholder's remittance of the Premium when due or if You are being billed directly, Your payment of the required Premium when due.

How To Use This Plan

We will pay Benefits for the dental services described in *Attachment A* subject to the limitations and exclusions described in *Attachment B*. We will pay Benefits only for covered services. Your Plan covers several categories of dental services when they are within the standards of generally accepted dental practice standards. Claims are processed in accordance with Our standard processing policies. We may use Dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period You are covered under any Delta Dental plan or prior dental care plan provided by the Contractholder. Additional eligibility periods, if any, are listed in *Attachment A*. If You receive dental services from a Dentist outside Your state of residence, the Dentist will be paid according to Our network payment provisions for Your state.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable, even when billed separately.

Coinsurance
We will pay a percentage of the applicable Maximum Allowance for covered services, as shown in *Attachment A,* and You are responsible for paying the balance which is referred to as Coinsurance. Coinsurance is part of Your out-of-pocket cost even after any Deductible has been met.

The amount of Your Coinsurance will depend on the type of service and the Dentist providing the service. Dentists are required to collect Coinsurance for covered services. Your Contractholder has chosen to require Coinsurances as a method of sharing the costs of providing dental Benefits between the Contractholder and You. If the Dentist discounts, waives or rebates any portion of the Coinsurance to You, We will be obligated to provide as Benefits only the applicable percentages of the Dentist's fees or allowances reduced by the amount of the fees or allowances that are discounted, waived or rebated.

It is to Your advantage to select PPO Dentists because they have agreed to accept the PPO Maximum Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for You. Refer to the *Selecting Your Dentist* and *How Claims Are Paid* sections for more information.

Deductible
Your Plan features a Deductible. This is an amount You must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in *Attachment A*. Deductibles apply to all Benefits unless otherwise noted. Only the Dentist fees You pay for covered Benefits will count toward the Deductible.

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

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

- the date the Contract terminates;
- the date Benefits are changed if the services in the Pre-Treatment Estimate are part of a Benefit change;
- the date Your coverage ends; or
- the date the Dentist's agreement with Us ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount We will pay when You are enrolled and meet all Plan requirements at the time the treatment is completed, and it may not consider any Deductibles.

Selecting Your Dentist – Free Choice of Dentist

We will provide Your Plan with PPO Dentists and Premier Dentists at convenient locations. You may see any Dentist for Your covered treatment, whether the Dentist is a PPO Dentist, Premier Dentist or a Non-Delta Dental Dentist.

Remember, You enjoy the greatest Benefits—including out-of-pocket savings—when You choose a PPO Dentist. To take full advantage of Your Plan, We highly recommend You verify a Dentist's participation status with Your dental office before each appointment. Review the *How Claims Are Paid* section to understand the method of payments applicable to Your Dentist selection and how Your selection may impact Your out-of-pocket costs.

Locating a PPO Dentist
To locate a PPO Dentist, You may access information through Our website at deltadentalins.com or contact Our Customer Service Center at 800-932-0783.

Continuity of Care
At Your request or the request of Your parent, guardian, designee or health care provider, We will accept a preauthorization from a relinquishing carrier for procedures, treatments, medications, or services covered by the Benefits offered by Us for the lesser of the course of treatment or 90 days.

At Your request or the request of Your parent, guardian, designee, or health care provider, We will allow You to continue to receive services for qualifying acute conditions and serious chronic conditions being rendered by a Non-Delta Dental Dentist or a Premier Dentist at the time of Your transition to Us and any other condition on which a Non-Delta Dental Dentist or a Premier Dentist and We reach agreement. You are allowed to continue to receive services for these conditions for the lesser of the course of treatment or 90 days. Coverage for these services will be subject to the Benefits, limitations and exclusions described in this EOC. You will be liable for the same fees, Deductibles, Coinsurances and Copayments, if applicable, that would be paid to a PPO Dentist for the same treatment. If a Non-Delta Dental Dentist does not accept Our method of compensation nor any allowed alternative, the Non-Delta Dental Dentist is not required to continue to provide the services.

Referrals to Specialists
You may continue care from a specialist if Your Dentist determines that You have a have a life-threatening, degenerative, chronic or disabling dental condition or dental disease that requires specialized dental care; and the specialist has expertise in treating the life-threatening, degenerative, chronic or disabling dental condition or dental disease and is a Delta Dental specialist. This standing referral is made in accordance with a written treatment plan for a covered service developed by Your Dentist, the Delta Dental specialist and You.

If You are diagnosed with a condition or disease that requires a specialist and no specialist who is a Delta Dental specialist has the specialized dental training and expertise to treat Your condition or disease or We cannot provide reasonable access to a Delta Dental specialist without unreasonable delay or travel, You may be referred to or consult a specialist who is not a Delta Dental specialist on Your own.

For purposes of calculating any Deductible, Coinsurance or Copayment, if applicable, payable by You, the specialist will be considered a Delta Dental specialist for Your treatment. Remember, if the specialist is not a Delta Dental specialist, You may be required to pay all of the treatment cost at the time of service and submit a claim to Us for reimbursement.

How Claims are Paid

PPO Dentist – Payment for Services
Payment for covered services provided by a PPO Dentist is calculated based on the lesser of the Dentist's Submitted Fee or the Maximum Allowance. PPO Dentists have agreed to accept the PPO Maximum Allowance as payment in full for covered services.

The portion of the Maximum Allowance payable by Us is limited to the applicable Contract Benefit Levels shown in *Attachment A*. Our payment is sent directly to the PPO Dentist who submitted the claim. We will advise You of any charges not payable by Us for which You are responsible. These charges are Your share of the Maximum Allowance, and any cost sharing features such as deductibles, charges where the maximum has been exceeded, any limitations or exclusions, and/or charges for non-covered services. You are encouraged to visit a PPO Dentist to reduce out-of-pocket costs.

Premier Dentist – Payment for Services
Payment for covered services provided by a Premier Dentist is calculated based on the lesser of the Dentist's Submitted Fee or the Maximum Allowance. A Premier Dentist is a contracted Dentist who is not contracted as a PPO Dentist and has not agreed to accept the PPO Maximum Allowance as payment in full for covered services. Rather, Premier Dentists have agreed to accept the Premier Maximum Allowance, which in most cases is higher than the PPO Maximum Allowance.

The portion of the Maximum Allowance payable by Us is limited to the applicable Contract Benefit Levels shown in *Attachment A*. Our payment is sent directly to the Premier Dentist who submitted the claim. We will advise You of any charges not payable by Us for which You are responsible. These charges are Your share of the Maximum Allowance, and any cost sharing features such as deductibles, charges where the maximum has been exceeded, any limitations or exclusions, and/or charges for non-covered services.

Under certain plan designs, regardless of whether You receive services from a PPO Dentist or a Premier Dentist, claims are paid based on the PPO Maximum Allowance. A Premier Dentist may bill the difference between the PPO Maximum Allowance and the Premier Maximum Allowance. In such instances, Your out-of-pocket expense will be higher than a visit to a PPO Dentist.

When seeking services from a Premier Dentist, You are encouraged to review the *Attachment A* to verify the Dentist's in-network status or contact Our Customer Service Center at 800-932-0783 for assistance.

Non-Delta Dental Dentist - Payment for Services
Payment for covered services provided by a Non-Delta Dental Dentist is calculated based on the lesser of the Dentist's Submitted Fee or the Maximum Allowance. Because these Dentists are not contracted, We cannot limit the amount charged to You. Seeking treatment from a Non-Delta Dental Dentist will generally result in higher out-of-pocket costs to You.

The portion of the Maximum Allowance payable by Us is limited to the applicable Contract Benefit Levels shown in *Attachment A*. Non-Delta Dental Dentists have no agreement with Us and are free to bill You for any difference between what We pay and the Submitted Fee.

You may be required to pay the Dentist and then submit a claim to Us for reimbursement. When dental services are received from a Non-Delta Dental Dentist, Our payment is sent directly to You unless You made an assignment of benefits to the Dentist.

We will advise You of any charges not payable by Us for which You are responsible. These charges are Your share of the Maximum Allowance, and any cost sharing features such as deductibles, charges where the maximum has been exceeded, any limitations and exclusions, and/or charges for non-covered services.

How to Submit a Claim
We do not require special *c*laim forms. However, most dental offices have claim forms available. PPO and Premier Dentists will submit Your claims paperwork for You. Non-Delta Dental Dentists may also provide this service upon Your request. If You receive services from a Non-Delta Dental Dentist who does not provide this service, You can submit Your claim directly to Us. Your dental office should be able to assist You in filling out the claim form. Claims should be submitted to:

Delta Dental of Pennsylvania
P.O. Box 2105
Mechanicsburg, PA 17055

Claim Forms
When We receive notice of a claim that does not contain all necessary information or is not on an appropriate claim form, forms for filing will be sent to You along with a request for any missing information. If these forms are not provided within 15 days, You will meet Our requirements if We are given written proof of the nature and extent of the loss.

Proofs of Loss
Written proof of loss (claims forms or other evidence of the claim that is ordinarily required) must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof of loss within the time required will not invalidate or reduce any claim if not reasonably possible to give proof within such time. However, proof of loss must be furnished as soon as reasonably possible.

Dentists have a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service.

Time Payment for Claims
All Benefits will be paid promptly as they become payable. We will pay or deny a claim within 60 days after receipt of proof of loss provided it contains all necessary information needed for payment of the claim.

Payment of Claims
All Benefits not paid to the Dentist will be payable to You as the Primary Enrollee, or Dependent Enrollee, or to the estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian, or to any relative by blood or connection by marriage of the individual who is considered by Us to be equitably entitled to the benefit up to an amount not exceeding $5,000.

Enrollee Complaint Procedure
Refer to Our Internal Appeal and Grievance Process Addendum attached to this *EOC*.

Coordination of Benefits
If You or Your Dependents are covered by any other plan and receive a service covered by this Plan and the other plan, Benefits will be coordinated with the exception of an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis. Personal injury protection benefits under a motor vehicle liability insurance policy will not be required to be paid before Benefits under this Plan. If this Plan is the "primary" plan, We will not reduce Benefits. If this Plan is the "secondary" plan, We may reduce Benefits so that the total Benefits paid or provided by all plans do not exceed 100% of total allowable expense. An allowable expense is a dental care expense, including Coinsurance, Copayments and applicable Deductible, which is covered in full or in part by any plan covering You. When a plan provides Benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

But if this Plan is the "secondary" plan, We determine Benefits after those of the primary plan and will pay the lesser of the amount that We would pay in the absence of any other dental Benefit coverage or Your total out-of-pocket cost under the primary plan for Benefits covered under Your Plan.

A plan does not include hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical services of long term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

In order to determine which plan is primary, We will use the following rules.

- The plan covering You as a Primary Enrollee is primary over a plan covering You as a Dependent.
- The plan covering You as an employee is primary over a plan covering You as a Dependent; except that if You are also a Medicare beneficiary, and because of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - Secondary to the plan covering You as a Dependent; and
    - Primary to the plan covering You as other than a Dependent (i.e., a retired employee), then the Benefits of the plan covering You as a Dependent are determined before those of the plan covering You as other than a Dependent.
- Except as stated above, when this Plan and another plan cover the same child as a Dependent of different persons, referred to as parents, who are married or are living together, whether or not they have ever been married:
    - The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    - If both parents have the same birthday, the Benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period.

- In the case of a Dependent child of legally separated, divorced parents, or parents not living together, whether or not they have ever been married:
    - If there is a court decree establishing that one of the parents has financial responsibility for the child's health care expenses, the Benefits of a plan covering the child as a Dependent of the parent with financial responsibility will be determined before the Benefits of any other policy covering the child as a Dependent child. If the parent with financial responsibility has no plan coverage, but that parent's spouse does, the parent's spouse's plan will be primary.
    - If the specific terms of a court decree state that both parents are financially responsible for the child's health care expenses, the plans covering the child will follow the order of Benefit determination rules outlined in the third bullet above.
    - If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child will follow the order of Benefit determination rules outlined in the third bullet above.
    - If there is no court decree establishing responsibility for the child's health care expenses, the order of Benefits for the child are as follows:
        - The plan covering the child as a dependent of the parent with legal custody;
        - The plan covering the child as a dependent of the custodial parent's spouse (i.e., step-parent);
        - The plan covering the child as a dependent of the parent without legal custody; and then
        - The plan covering the child as a dependent of the non-custodial parent's spouse.
- For a dependent child covered under more than one plan of individuals who are not parents of the child, the plans covering the child will follow the order of Benefit determination rules outlined in the third or fourth bullet above as if those individuals were parents of the child.
- For a dependent child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan, the plan covering the child will follow the order of Benefit determination rules outlined in the ninth bullet below.
    - In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plans covering the child will follow the order of Benefit determination rules in the third bullet above applied to the dependent child's parent(s) and the dependent's spouse.
- The Benefits of a plan covering You as an employee, if applicable, who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same holds true if You are a Dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If Your coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.
    - First, the Benefits of a plan covering You as an employee, if applicable, or Primary Enrollee (or the Primary Enrollee's Dependent).
    - Second, the Benefits under the continuation coverage.

  If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If none of the above rules determines the order of Benefits, the Benefits of the plan covering You as an employee longer are determined before those of the plan covering You for the shorter term.
- When determination cannot be made in accordance with the rules above, the allowable expenses will be shared equally between the plans.

Renewal and Termination of Benefits

This Plan renews on the anniversary of the Contract unless We provide at least 45 days advance notice of a change in Premiums or Benefits and the Contractholder does not accept the change. Your Benefits will terminate:

- As of the date this Plan is terminated,
- You cease to be eligible under the terms of this Plan, or
- Your enrollment is canceled under the terms of this Plan.

We are not obligated to continue to provide Benefits to You or Your Dependents except for completion of dental treatment started when this Plan was in effect. Refer to the *Continuation of Benefits* section for additional information.

Cancellation of Enrollment
Subject to the *Continued Coverage under USERRA* provisions, Your enrollment may be canceled, or renewal of enrollment refused, in the following events:

Immediately:
- Upon loss of eligibility as determined by the Contractholder; or
- If You engage in conduct detrimental to safe operations and the delivery of services while receiving services from a PPO or Premier Dentist.

Upon 15 days written notice if:

- The Premiums are not paid by, or on behalf of You, on the date due. However, You may continue to receive Benefits during the Grace Period and may be reinstated during the term of the Contract upon payment of any unpaid Premium; or
- You knowingly commit or permit another person to commit fraud or deception in obtaining Benefits.

Upon 30 days written notice if:

- The Contract is terminated or not renewed; or
- You fail to pay Coinsurances and/or Deductibles, if applicable. However, You may be reinstated during the term of the Contract upon payment of all delinquent charges.

The Contractholder will provide You with 15 days advance notice prior to cancellation or discontinuance of this Plan.

Cancellation of Your enrollment will automatically cancel the enrollment of any of Your Dependent Enrollees.

General Provisions

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

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 information including executing any agreements as required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The parties agree that the Contract will incorporate terms as necessary and as applicable to execute the required agreements (i.e., business associate agreement) to comply with federal regulations issued under the HIPAA and Health Information Technology for Economic and Clinical Health (“HITECH”) Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

Entire Contract
The Contract, including this *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.

Incontestability
After the Contract has been in force for two (2) years from the Effective Date, no statement made by the Contractholder will be used to void the Contract. No statement by any person, if applicable, or You with respect to Your insurability will be used to reduce or deny a claim or contest the validity of services for You after Your coverage has been in effect two (2) years or more during Your lifetime.

No claims for loss incurred or disability commencing after two (2) years from the date of issue of the 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 the Contract.

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

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

Severability
If any part of the Contract, this *EOC* or any attachment is found by a court or other authority to be illegal, void or not enforceable, all other portions of these documents will remain in full force and effect.

Strike, Lay-off and Leave of Absence
You will not be covered for any dental services received while on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 ("FMLA") or other applicable state or federal law*.

*Your coverage is not affected if You take a leave of absence under the FMLA or other applicable state or federal law. If You are currently paying any part of the Premium, You may choose to continue coverage. If You do not continue coverage during the leave, coverage may be resumed upon Your return to active work as if no interruption occurred.

Important: FMLA does not apply to all organizations, only those that meet certain size guidelines. Refer to Your Human Resources unit for complete information.

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

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

If You need these services, contact Our Customer Service Center at 800-932-0783.

If You believe that We have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, You can file a grievance electronically online, over the phone with a representative, or by mail.

Delta Dental
P.O. Box 997100
Sacramento, CA 95899
Telephone Number: 800-471-0275
Website Address: deltadentalins.com

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

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

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

INTERNAL APPEAL AND GRIEVANCE PROCESS ADDENDUM

Delta Dental of Pennsylvania
300 Corporate Center Drive, Suite 600
Camp Hill, PA 17011

This Addendum provides important information regarding Coverage Decisions and Adverse Decisions and is effective on the Effective Date stated in the group Contract. This Addendum is attached to and made part of the EOC.

DEFINITIONS

Throughout this Addendum "You" refers to "You," "Your Representative" and "Your treating provider" and "We," "Us" and "Our" refers to Delta Dental of Pennsylvania or its Administrator or private review agent.

You: Includes the Enrollee and any Dependents, and Medicare recipients who are or may be entitled to dental care services. It does not include a Medicaid recipient.

Your Representative: An individual who You have authorized to file an Appeal, Grievance or Complaint on Your behalf.

Health Advocacy Unit: The Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

NOTICES

Notices will be provided in a culturally and linguistically appropriate manner.

COVERAGE DECISIONS

The section applies to Appeals and Complaints involving Coverage Decisions as defined below.

Definitions
The following terms will assist You with a better understanding of Our internal appeal process.

Appeal: A protest regarding a Coverage Decision filed through Our internal appeal process.

Appeal Decision: A final determination by Us that arises from an Appeal filed through Our internal appeal process regarding a Coverage Decision.

Complaint: A protest filed with the Maryland Insurance Commissioner ("Commissioner") involving a Coverage Decision other than that which is covered by the complaint process for Adverse Decisions or Grievances.

Coverage Decision means:

- An initial determination by Us that results in noncoverage of a dental care service;
- A determination by Us that You are not eligible for coverage; or
- Any determination by Us that results in the rescission of Your coverage.
- Coverage Decision includes nonpayment of all or any part of a claim. A Coverage Decision does not include an Adverse Decision.

Urgent Medical Condition: A condition that satisfies either of the following:

- A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of Us, applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
  - Placing Your life or health in serious jeopardy;
  - The inability for You to regain maximum function;
  - Serious impairment to bodily function;
  - Serious dysfunction of any bodily organ or part; or
  - You remaining seriously mentally ill with symptoms that cause You to be a danger to Yourself or others; or
- A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge or Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is subject of the Coverage Decision.

Coverage Decision

We rely on the professional judgment of Dentists to determine the appropriate treatment required for You, and We make Coverage Decisions by reviewing claims to determine whether the rendered services are covered under the terms of Your Plan.

We do not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, We do not conduct concurrent review relating to continued or extended dental services, or additional services for an insured undergoing a course of continued treatment.

Unlike medical coverage, it is unlikely that a life-threatening situation should arise, or even more unlikely due to the nature of dental care that You would need to receive authorization for an extended hospital stay or medical treatment. If You must seek emergency dental treatment, You do not need to obtain pre-authorization to seek services.

Coverage Decision Notice

Within 30 calendar days after a Coverage Decision has been made, We will provide written notice of the decision to You.

The Coverage Decision notice will include the following information:

- Factual basis for Our decision in clear, understandable language;
- Notice of the right to file an Appeal with Us;
- Notice of the right to file a Complaint with the Commissioner without first filing an Appeal if the Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;
- The Commissioner's address, telephone number, and facsimile number;
- A statement that the Health Advocacy Unit is available to assist in both mediating and filing an Appeal through Our internal appeal process; and
- The address, telephone number, facsimile number, and email address of the Health Advocacy Unit.
- You may request a second opinion if You disagree with or question the Dentist’s diagnosis and/or proposed treatment plan. We may also request that You obtain a second opinion to verify appropriate application of Benefits. Second opinions will be provided by another Dentist, unless otherwise authorized by Us. You may contact Customer Service at 800-932-0783 to request a second opinion. We will provide notice if any dental services are not covered Benefits, stating the specific contractual reason(s) for Our decision. Questions concerning eligibility, Our policies, procedures or operations may be addressed with Customer Service.

Appeal Process

If You are dissatisfied with Our Coverage Decision, You may request review of the Coverage Decision by submitting an Appeal with Us within 180 days after receipt of the Coverage Decision notice.

An Appeal may be requested orally from Customer Service at 800-932-0783 or in writing to the Quality Management Department at the following address:

Quality Management Department
P.O. Box 2105
Mechanicsburg, PA 17055

The Appeal request should include the following information:

- The patient's name, address, telephone number, Enrollee ID number, and the treating Dentist's name and address;
- A statement as to why the claim should not have been denied and include any other documents, data, information or comments which may have bearing on the claim; and
- Your request to receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim.
- Within five (5) working days of the filing of Your request, We will provide written acknowledgement, and if necessary, We will advise and identify if any additional information is necessary to review Your request.

Appeal Review
The review will be conducted by a person who is neither the individual who made the Coverage Decision that is the subject of the review, nor the subordinate of such individual. We will consider all comments, documents, records, and or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

Appeal Decision
We will make a final decision within 60 working days after the date the Appeal is filed. This period may be extended with Your written consent for a period no longer than 30 working days. Within 30 calendar days after the Appeal Decision has been made, We will provide written notice of the decision to You.

The Appeal Decision notice will include the following information:

- Factual basis for Our decision in clear, understandable language;
- Notice of the right to file a Complaint with the Commissioner within four (4) months after receipt of Our Appeal Decision;
- The Commissioner's address, telephone number, and facsimile number;
- A statement that the Health Advocacy Unit is available to assist in filing a Complaint with the Commissioner; and
- The address, telephone number, facsimile number, and email address of the Health Advocacy Unit.

Complaints to the Commissioner
You must exhaust Our internal appeal process before filing a Complaint with the Commissioner; however, if Your Complaint concerns any of the following, You do not need to exhaust Our internal appeal process before filing a Complaint:

- An Urgent Medical Condition for which care has not been rendered, or
- A concern regarding the quality of care received.

Complaints to the Commissioner must be in writing and include Your name, address, telephone number as well as the reasons for filing the Complaint accompanied by any copies of materials important to Your Complaint. The Commissioner may request that You sign a consent form authorizing the release of medical (dental) records to the Commissioner or their designee that are needed in order to make a final decision on the Complaint.

The Commissioner may be contacted at:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 1-800-492-6116 or 410-468-2000
TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260
Email: agcomplaints.mia@maryland.gov

Health Advocacy Unit Assistance
The Health Advocacy Unit can assist You in both mediating and filing an Appeal through Our internal appeal process or in filing a Complaint with the Commissioner. The Health Advocacy Unit is not available to represent or accompany You during any internal appeal proceeding.

The Health Advocacy Unit may be contacted at:

Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 877-261-8807
TTY: 410-576-6372
Fax: 410-576-6571
Email: heau@oag.state.md.us

ADVERSE DECISIONS

The section applies to Grievances and Complaints involving Adverse Decisions as defined below.

Definitions
The following terms will assist You with a better understanding of Our internal grievance process.

Adverse Decision: A utilization review determination by Us that a proposed or delivered dental service is or was not medically necessary, appropriate, or efficient; and may result in noncoverage of the service. An Adverse Decision does not include a decision concerning Your status as an Enrollee.

Compelling Reason: To show that potential delay imposed by filing with Us could result in loss of life; serious impairment to a bodily function; serious dysfunction of a bodily organ; You remaining seriously mentally ill or using intoxicating

substances with symptoms that cause You to be a danger to Yourself or others; or You continuing to experience severe withdrawal symptoms.

Since Adverse Decisions are rendered after dental services are delivered, there is no Compelling Reason to show potential delay.

Complaint: A protest filed with the Commissioner involving an Adverse Decision or Grievance Decision.

Grievance: A protest regarding an Adverse Decision filed through Our internal grievance process.

Grievance Decision: A final determination by Us that arises from a Grievance filed through Our internal grievance process regarding an Adverse Decision.

Adverse Decision
Utilization review decisions are conducted by licensed Dentists in accordance with standards developed with input from a Dentist of the appropriate specialty. We use written medically/dentally acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from Dentists, including practicing Dentists, and other health care providers.

Pre-Authorization (Pre-Service) and Concurrent Reviews
We do not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, We do not conduct concurrent review relating to continued or extended dental services, or additional services for an insured undergoing a course of continued treatment.

Unlike medical coverage, it is unlikely that a life-threatening situation should arise, or even more unlikely due to the nature of dental care that You would need to receive authorization for an extended hospital stay or medical treatment. If You must seek emergency dental treatment, You do not need to obtain pre-authorization to seek services.

We do not make Adverse Decisions on urgent or emergency dental services.

Retrospective (Post-Service) Reviews
Adverse Decisions are rendered after dental services are delivered.

Adverse Decision Notice
We will provide oral communication of the Adverse Decision to You. Within five (5) working days after an Adverse Decision has been made, We will provide written notice of the decision to You.

The Adverse Decision notice will include the following information:

- Factual basis for Our decision in clear, understandable language;
- References to the specific criteria and standards, including interpretive guidelines, on which Our decision was based;
- The name, business address, and business telephone number of the designated employee or representative who has responsibility for Our internal grievance process;
- Written details of Our internal grievance process and procedures;
- Notice of the right to file a Complaint with the Commissioner within four (4) months after receipt of Our Adverse Decision;
- Notice of the right to file a Complaint with the Commissioner without first filing a Grievance if there exists a Compelling Reason to do so;
- The Commissioner's address, telephone number, and facsimile number;
- A statement that the Health Advocacy Unit is available to assist in both mediating and filing a Grievance through Our internal grievance process; and

- The address, telephone number, facsimile number, and email address of the Health Advocacy Unit.

Grievance Process

Informal Inquiry Option
If a claim is denied in whole or in part, You may make an informal inquiry regarding the general program, eligibility questions and Adverse Decisions by contacting Us at 800-932-0783.

Grievance
If You are dissatisfied with Our Adverse Decision, You may request review of the Adverse Decision by submitting a Grievance with Us within 180 days after receipt of the Adverse Decision notice.

A Grievance may be requested orally from Customer Service at 800-932-0783 or in writing to the Quality Management Department at the following address:

Quality Management Department
P.O. Box 2105
Mechanicsburg, PA 17055

Your Grievance request should include the following information:

- The patient's name, address, telephone number, Enrollee ID number, and the treating Dentist's name and address;
- A statement as to why the claim should not have been denied and include any other documents, data, information or comments which may have bearing on the claim including the denial notice; and
- Your request to receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim.

Within five (5) working days of the filing of Your request, We will provide written acknowledgement, and if necessary, We will advise and identify if any additional information may be necessary to review Your request.

Grievance Review
The review will be conducted by a licensed Dentist or a panel of appropriate reviewers with at least one Dentist on the panel who is a licensed Dentist. We will consult with a Dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the dental consultant who made the claim denial nor the subordinate of such individual. The identity of the dental consultant whose advice was obtained will be made available upon request whether or not the advice was relied upon. In making the review, We will not afford deference to the initial Adverse Decision. A clinical examination at Our cost may be implemented, along with discussion among dental consultants.

Grievance Decision
We will make a final decision within 45 working days after the date the Grievance is filed. This period may be extended with Your written consent for a period of no longer than 30 working days.

We will provide oral communication of the Grievance Decision to You. Within five (5) working days after the Grievance Decision has been made, We will provide written notice of the decision to You.

The Grievance Decision notice will include the following information:

- Factual basis for Our decision in clear, understandable language;
- References to the specific criteria and standards, including interpretive guidelines, on which Our decision was based;
- The name, business address, and business telephone number of the designated employee or representative who has responsibility for Our internal grievance process;
- Notice of the right to file a Complaint with the Commissioner within four (4) months after receipt of Our Grievance Decision;
- The Commissioner's address, telephone number, and facsimile number;
- A statement that the Health Advocacy Unit is available to assist in filing a Complaint with the Commissioner; and
- The address, telephone number, facsimile number, and email address of the Health Advocacy Unit.

Our Grievance Decision is considered final. Recourse thereafter would be to the Commissioner.

Complaints to the Commissioner
You may file a Complaint with the Commissioner without first filing a Grievance with Us and receiving a final decision on the Grievance if:

- We waive the requirement that Our internal grievance process be exhausted before filing a Complaint with the Commissioner;
- We have failed to comply with Our internal grievance process requirements;
- You provide sufficient information and supporting documentation in the Complaint that demonstrates a Compelling Reason to do so.

Complaints to the Commissioner must be in writing and include Your name, address, telephone number as well as the reasons for filing the Complaint accompanied by any copies of materials important to Your Complaint. The Commissioner may request that You sign a consent form authorizing the release of medical (dental) records to the Commissioner or their designee that are needed in order to make a final decision on the Complaint.

The Commissioner may be contacted at:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievances
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 1-800-492-6116 or 410-468-2000
TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260
Email: agcomplaints.mia@maryland.gov

Health Advocacy Unit Assistance

The Health Advocacy Unit can assist You in both mediating and filing a Grievance through Our internal grievance process or in filing a Complaint with the Commissioner. The Health Advocacy Unit is not available to represent or accompany You during any internal grievance proceeding.

The Health Advocacy Unit may be contacted at:

Office of the Attorney General
Health Education and Advocacy Unit
00 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 877-261-8807
TTY: 410-576-6372
Fax: 410-576-6571
Email: heau@oag.state.md.us

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If Your Plan is subject to the 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 Your rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The U.S. Department of Labor may be contacted at:

U.S. Department of Labor
Employee Benefits Security Administration (EBSA)
200 Constitution Avenue, N.W.
Washington, D.C. 20210

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders and contract holders. This safety net was created under Maryland law, which determines who and what iscovered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debtsof the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State ofMaryland.

The Corporation was established to provide protection in the unlikely event that your health maintenance organization or your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If thisshould happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Corporation are:

- Life Insurance
    - $300,000 in death benefits
    - $100,000 in cash surrender or withdrawal values
- Health Insurance or Health Benefit Plans
    - $500,000 for coverage provided by health benefit plans
    - $300,000 for disability insurance
    - $300,000 for long-term care insurance
    - $100,000 for a type of health insurance not listed above, including any net cashsurrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
    - $250,000 in the present value of annuity benefits, including net cash withdrawalvalues and net cash surrender values
    - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values.
- The maximum amount of protection for each individual, regardless of the number ofpolicies or contracts, is:
    - $300,000 in aggregate for all types of coverage listed above, with the exceptionof coverage provided by health benefit plans
    - $500,000 in aggregate for coverage provided by health benefit plans

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurancepolicy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website atwww.mdlifega.org, or contact:

Maryland Life and Health Insurance Guaranty Corporation
6210 Guardian Gateway
Suite 195APG
Aberdeen, Maryland 21005
410-248-0407

Insurance companies, health maintenance organization, and insurance producers are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourageyou to purchase any form of insurance or a health benefit plan. When selecting an insurance company or health maintenance organization, you should not rely on Corporation coverage. Ifthere is any inconsistency between this notice and Maryland law, then Maryland law will control.

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

Contractholder: University of Maryland - Student Plan **Group Number:** 22907

Effective Date: August 1, 2024

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

Description of Dental Benefits	
Dental Benefit **Benefit Category**	**Dental Benefit Description**
Exams Diagnostic and Preventive	evaluation to assess oral health
X-Rays Diagnostic and Preventive	radiographic imaging services to aid diagnosis
Prophylaxis Diagnostic and Preventive	services to remove plaque, tartar and stains from the tooth surface
Fluoride Diagnostic and Preventive	topical application of fluoride in the dental office
Space Maintainers Diagnostic and Preventive	oral appliance made to “maintain” the space created by the loss of a tooth
Sealants Diagnostic and Preventive	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay
Minor Restorative Basic	amalgam (silver filling) and resin-based composite (tooth-colored filling) and prefabricated crowns for treatment of decay, failing restorations or fractures
Endodontics Basic	treatment of diseases and injuries of the tooth pulp
Periodontics; Surgical Basic	surgical treatment of gums and bones supporting teeth
Periodontics; Non-Surgical Basic	non-surgical treatment of gums and bones supporting teeth
Periodontal Maintenance Basic	a cleaning performed to maintain periodontal health after periodontal treatment
Denture Repair/Rebase/Reline Basic	repair to partial or complete dentures, including rebase procedures and relining
Extractions Basic	removal of teeth
Surgical Extractions Basic	removal of teeth by opening the gums and removing bone
Other Oral Surgery Basic	oral surgery services with the exception of surgical and non-surgical extractions
Palliative Treatment Basic	treatment to relieve pain
IV Sedation & General Anesthesia Basic	when administered by a Dentist for Oral Surgery or selected endodontic and periodontal surgical procedures
Consultation Basic	opinion or advice requested by a Dentist
Major Restorative Major	treatment of decay and fracture when teeth cannot be restored with amalgam (silver filling) or resin-based composites (tooth-colored filling)

Prosthodontics; Removable	procedures for construction, modification and repair of partial or complete dentures
Major	
Prosthodontics; Fixed	procedures for construction, modification and repair of fixed bridges
Major	
Cone Beam CT	x-ray technique that captures multiple images of the head and neck from a variety of angles
Major	
Resin-based Composites - Posterior	resin-based composite (tooth-colored fillings) in the rear of the mouth for treatment of decay, failing restorations or fractures
Basic	

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

Deductibles	
Annual Deductible	$100 per Enrollee
Deductibles waived for	Diagnostic & Preventive Benefits provided by a PPO Dentist

Maximums	
Annual Maximum	$1,000

Contract Benefit Levels
Our reimbursement to Dentists is based on PPO Maximum Contract Allowance for PPO Dentists, PPO Maximum Contract Allowance for Premier Dentists and PPO Maximum Contract Allowance for Non-Delta Dental Dentists. We will pay the Contract Benefit Level for the following Benefits. You are responsible for paying the balance not paid by Us which is referred to as Coinsurance. The amount of Coinsurance will depend on the Benefit category and the Dentist providing the service.

Dental Benefit Category	**PPO Dentists**	**Non-Delta Dental Dentists**
Diagnostic and Preventive	100%	100%
Basic	80%	70%
Major	50%	40%

Delta Dental of Pennsylvania is a private not-for-profit corporation.

Attachment B
Limitations and Exclusions

Contractholder: University of Maryland - Student Plan **Group Number:** 22907

Contract Term: Contract Year (unless otherwise specified)

Effective Date: August 1, 2024

Limitations

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

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

- Exam and cleaning limitations:
  - We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than twice in a Contract Year.
  - Full mouth debridement is not allowed when performed by the same Dentist/Dentist office on the same day as evaluation procedures.
  - A full mouth debridement is allowed once in a lifetime when You have no history of prophylaxis, scaling and root planing, periodontal surgery or periodontal maintenance procedures within three (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
  - Note that periodontal maintenance, Procedure Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit and that routine cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
  - Caries risk assessments are allowed once in 12 months.

- Image limitations:
  - We will limit the total reimbursable amount to the Dentist's Submitted Fee for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Submitted Fee for a comprehensive intraoral series.
  - If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Dentist's Submitted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be Your responsibility. Panoramic images are not considered part of a comprehensive intraoral series.
  - Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
  - Bitewing images are limited to two (2) times in a Contract Year when provided to Enrollees under age 18 and one (1) time each Contract Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
  - Bitewing images of any type are included in the fee of a comprehensive series when taken within six (6) months of the comprehensive images.
  - Bitewing images are limited to two (2) images for Dependent Enrollee children under age 10.
  - Image capture procedures are not separately billable services.

- Cone Beam CT capture and interpretation are covered not more than once in any 12 month period. Interpretation of a diagnostic image only is covered for cone beam services. Cone beam interpretation is a covered Benefit when provided by a different Dentist/Dentist office than the Dentist/Dentist office who provided the cone beam capture only services.

- Topical application of fluoride solutions is limited to age 19 and no more than twice in a Contract Year.

- Application of caries arresting medicament is limited to twice per tooth per Contract Year.

- Space maintainer limitations:
  - Space maintainers are limited to the initial appliance and are a Benefit for Dependent Enrollee children to age 14. A distal shoe space maintainer-fixed-unilateral is limited to Dependent Enrollee children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
  - Recementation of space maintainer is limited to once per lifetime.
  - The removal of a fixed space maintainer is included in the fee. An exception is made if the removal is performed by a different Dentist/Dentist office.

- Pulp vitality tests are allowed once per day when definitive treatment is not performed.

- Sealants are limited as follows:
  - for Dependent Enrollee children through age 15 on permanent first and second molars if the molars are without caries (decay) or restorations on the occlusal surface.
  - repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.

- Specialist Consultations are limited to once per lifetime per Dentist and count toward the oral exam frequency. Screenings or assessments reported individually when covered are limited to only one (1) in a 12-month period and included if reported with any other examination on the same date of service and Dentist office.

- We will not cover replacement of an amalgam or resin-based composite restoration (filling) or prefabricated crowns within 24 months of treatment if the service is provided by the same Dentist/Dentist office. Replacement restorations within 24 months are included in the fee for the original restoration.

- Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

- Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth for Dependent Enrollee children to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.

- Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

- Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Dentist/Dentist office within 24 months is considered part of the original procedure.

- Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit for Dependent Enrollees to age 19.

- Retreatment of apical surgery by the same Dentist/Dentist office within 24 months is considered part of the original procedure.

- Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select Diagnostic procedures.

- Periodontal limitations:
  - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be covered on the same date of service.
  - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Dentist/Dentist office.
  - Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
  - Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
  - Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Dentist office.

- Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

- Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or the frenum is contributing to the presence of a large diastema(s).

- Crowns with no limiting age and inlays/onlays are limited for Dependent Enrollee children to age 12 and older and are covered not more often than once in any 60-month period except when We determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

- Core buildup, including any pins, are covered not more than once in any 60-month period.

- Post and core services are covered not more than once in any 60-month period.

- Crown repairs are covered not more than twice in any 60-month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.

- When allowed within six (6) months of a restoration, the Benefit for a crown, inlay/onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

- Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than twice in any 60-month period.

- Prosthodontic appliances that were provided by Us will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to age 16 and older. Replacement of a prosthodontic appliance not provided by Us will be made if We determine it is unsatisfactory and cannot be made satisfactory.

- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

- Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Dentist/Dentist office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime.

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

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

  - Tissue conditioning is limited to two (2) per arch in a 12-month period. Tssue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
  - Recementation of fixed partial dentures is limited to once in a lifetime.

- We will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but We will credit the cost of a pontic or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture. The implant appliance is not covered.

- The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

Exclusions

We do not pay Benefits for:

- Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Maxillofacial prosthetics.
- Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for Dependent Enrollee children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- Services for congenital (hereditary) or developmental (following birth) malformations, services for treatment of cleft lip and/or palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn Dependent Enrollee children for medically diagnosed congenital defects or birth abnormalities.
- Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion.
- Any Single Procedure provided prior to the date the Enrollee became eligible for Benefits under this Plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- Charges for anesthesia, other than General Anesthesia and IV Sedation in connection with Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- Extra oral grafts (grafts of tissues obtained from extraoral sites of the Enrollee's own body to their oral tissues).
- Fixed bridges and removable partials for Dependent Enrollee children under age 16.
- Interim implants, endodontic endosseous implant and extraoral implants.
- Indirectly fabricated resin-based inlays/onlays.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening or tobacco counseling.
- Dental practice administrative services, preparation of claims, preparing and maintenance of treatment records, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment and infection control, ancillary materials used during the routine course of providing treatment, relaxation techniques, patient management, and case management services.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- Deductibles, amounts over plan maximums and/or any service not covered under this Plan.
- Services covered but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefits section.

- Services for any disturbance of TMJ or associated musculature, nerves and other tissues except as provided under the TMJ Benefit section.
- Missed and/or cancelled appointments.
- Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- Dental case management motivational interviewing and patient education to improve oral health literacy.
- Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- Diabetes testing.
- Corticotomy (specialized Oral Surgery procedure associated with Orthodontics).
- Antigen or antibody testing.
- Counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use.
- Services or supplies for sleep apnea.
- Cone beam image capture only is not a covered Benefit.
- Claims, bills or other demands or requests for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

Delta Dental of Pennsylvania is a private not-for-profit corporation

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.

This notice is required by law to inform you of how Delta Dental and its affiliates ("Delta Dental") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. 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. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

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 about yourself for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. 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 for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations 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. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

Other 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. Delta Dental 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 Delta Dental makes with your authorization

Delta Dental 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. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

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 contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does 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. Please contact Delta Dental as noted below if you have questions about access to your PHI.

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. If we accept your request, we will put our understanding in writing.

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. 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 dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have rights related to the use and disclosure of your PHI for marketing.
Delta Dental agrees to obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the opportunity to opt-out of marketing that is permitted by law without an authorization. Delta Dental does 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.
Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger,

as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email.
A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.

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

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

COMPLAINTS

You may file a complaint with Delta Dental and/or with the U. S. Secretary of Health and Human Services if you believe Delta Dental has violated your privacy rights. Complaints to Delta Dental may be filed by notifying the contact below. We will not retaliate against you for filing a complaint.

CONTACTS

You may contact Delta Dental at 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
P.O. Box 997330
Sacramento, CA 95899-7330

This notice is effective on and after January 1, 2017.

Note: Delta Dental's privacy practices reflect applicable federal law as well as known state law and regulations. If applicable state law is more protective of information than the federal privacy laws, Delta Dental protects information in accordance with the state law.

Last Significant Changes to this notice:

- Clarified that Delta Dental does not use your PHI for fundraising purposes. Effective January 1, 2016
- Clarified that Delta Dental's privacy policy reflect federal and state requirements. – effective January 1, 2015
- Updated contact information (mailing address and phone number) – effective July 1, 2013
- Updated Delta Dental's duty to notify affected individuals if a breach of their unsecured PHI occurs – effective July 1, 2013
- Clarified that Delta Dental does not and will not sell your information without your express written authorization – effective July 1, 2013
- Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above) – effective July 1, 2013

DELTA DENTAL AND ITS AFFILIATES

Delta Dental of California offers and administers fee-for-service dental programs for groups headquartered in the state of California.

Delta Dental of New York offers and administers fee-for-service programs in New York.

Delta Dental of Pennsylvania and its affiliates offer and administer fee for-service dental programs in Delaware, Maryland, Pennsylvania, West Virginia and the District of Columbia.

Delta Dental of Pennsylvania's affiliates are Delta Dental of Delaware; Delta Dental of the District of Columbia and Delta Dental of West Virginia.

Delta Dental Insurance Company offers and administers fee-for-service dental programs to groups headquartered or located in Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas and Utah and vision programs to groups headquartered in West Virginia.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, ME, MI, NC, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN and WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Dentegra Insurance Company.

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-521-2651 (TTY: 711).

¿Puede leer este documento? Si no, podemos hacer que alguien lo lea por usted. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-521-2651 (TTY: 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-521-2651 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-521-2651 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 그렇지 않다면, 다른 사람이 대신 읽어드리도록 도와드릴 수 있습니다. 또한 이 문서를 귀하의 모국어로 번역해드릴 수 있습니다. 무료 지원을 요청하시려면, 1-800-521-2651 (TTY: 711)번으로 연락하십시오. (Korean)

Mababasa mo ba ang dokumentong ito? Kung hindi, mayroong makatutulong sa iyo na basahin ito. Maaaring makuha mo rin ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-521-2651 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, то вы можете попросить кого-нибудь в нашей компании помочь вам прочитать этот документ. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-521-2651 (TTY: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع, يمكننا أن نُوفّر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك. للمساعدة المجانية اتصل بـ 1-800-521-2651 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-521-2651 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n’est pas le cas, nous pouvons faire en sorte que quelqu’un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l’assistance gratuitement, veuillez appeler le 1-800-521-2651 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-521-2651 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-521-2651 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche essere in grado di ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-521-2651 (TTY: 711). (Italian)

この文書をお読みになれますか？お読みになれない場合には、読むためのお手伝いをさせていただけます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-521-2651 (TTY: 711) までご連絡ください。 (Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-521-2651 (TTY: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیا تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-521-2651 (TTY: 711). (Persian Farsi)

קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט, עמעצער דו קען אייך העלפן לייענען. איר קענט מעגליך אויך באקומען דעם דאָזיקן דאָקומענט אין אייער שפראך. פאר אומזיסטע הילף, ביטע קלינגט: 1-800-521-2651 (TTY: 711). (Yiddish)

Díísh yíníłta’go bíníghah? Doo bíníghahgóó éí nich’į’ yídóołtahígíí nihee hóló. Díí naaltsoos t’áá Diné bizaad k’ehjí ályaago ałdó’ nich’į’ ádoolnį́į́łgo bíighah. T’áá jíík’e shíká i’doolwoł nínízingo kojį’ béésh holdíílnih 1-800-521-2651 (TTY: 711). (Navajo)