Delta Dental of New York, Inc.

TOWN OF RIVERHEAD

deltadentalins.com

Group No: 22980

Effective Date: September 1, 2024

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Attachment(s)

SECTION I. INTRODUCTION

We are pleased to welcome You to the group dental plan for **Town of Riverhead**. Your plan is underwritten and administered by Delta Dental of New York, Inc. ("Delta Dental").

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between Delta Dental of New York, Inc. (hereinafter referred to as "We", "Us", or "Our") and the Group listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on two benefit levels:

1. In-Network Benefits. In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our Delta Dental PPO℠ Network. You should always consider receiving dental care services first through the in-network benefits portion of this Certificate.

2. Out-of-Network Benefits. The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

This Certificate is *not* a Summary Plan Description to meet the requirements of ERISA.

Notice: *This Certificate is a summary of Your group dental program. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

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

You can access our automated information line at 800-932-0783 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If You prefer to write Us with Your question(s), please mail Your inquiry to the following address:

Delta Dental of New York, Inc.
150 East 58th St., 24th Fl.
New York, New York 10155

The insurance evidenced by this Certificate provides DENTAL insurance ONLY.

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

SECTION II. DEFINITIONS

Terms when capitalized in Your Certificate have defined meanings, given in the section below or throughout the Certificate sections.

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

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Benefits: the amounts that Delta Dental will pay for covered dental services under the Contract.

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

Certificate: This Certificate issued by Delta Dental, including any attached riders/amendments or Attachments. This Certificate explains the benefits available to You under the Group Contract and is a part of the Group Dental Contract.

Child, Children: the Subscriber's Children, including any natural, adopted or step-Children, unmarried disabled Children, newborn Children, or any other Children as described in the Eligibility and Enrollment section of this Certificate.

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

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service**.**

Contract: the Contract entered into between Delta Dental and the Group, and any Attachments, Amendments or riders attached to the Contract.

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

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

Cost Sharing Amounts: You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before We begin paying Benefits.

Deductible Takeover: any Deductible You incurred for services while covered under Your employer's former dental plan that was replaced by this dental plan will be credited towards the satisfaction of the Deductible under this plan.

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

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

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

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

Dependents: The Subscriber's Spouse and Children enrolled to receive Benefits.

Effective Date: the original date the Contract starts. This date is given on this Certificate's cover and Attachment A.

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

Eligible Employee: any employee or retiree as eligible for Benefits.

Exclusions: Dental care services that We do not pay for or Cover.

External Appeal Agent: an entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York Law.

Grievance: a complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: the employer or party that has entered into an agreement with Us as a Contractholder.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

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

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

Medically Necessary: See the Conditions Under Which Benefits Are Provided section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee. Member may also be referred to as "Enrollee"

Non-Participating Provider: A Provider who doesn't have a contract with Us (a PPO Provider or a Premier Provider) to provide services to You and is not contractually bound to abide by Delta Dental's administrative guideline You will pay more to see a Non-Participating Provider. Non-Delta Dental Providers are considered Non-Participating Providers.

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

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at deltadentalins.com or upon Your request to Us. The list will be revised from time to time by Us. Delta Dental Premier Providers and Delta Dental PPO Providers are considered Participating Providers.

Premium: the amount that must be paid for Your dental insurance coverage.

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

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

Program Allowance: the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

Provider: an appropriately licensed, registered or certified dentist, dental hygienist, or dental assistant under Title 8 of the New York Stated Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under this Certificate.

Qualifying Status Change: a change in:

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

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of all counties within New York State.

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

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

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

Subscriber: the person to whom this Certificate is issued.

Subscriber's Effective Date of Coverage: the date the Group reports coverage will begin for each Subscriber and each Dependent.

Us, We, Our: Delta Dental of New York, Inc., and any entity to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: the review to determine whether services are Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION III. PREMIUMS

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

We may cancel the Contract 31 days after written notice to the Group if monthly premiums are not paid when due.

SECTION IV. ELIGIBILITY AND ENROLLMENT

Eligibility Requirements

An employee becomes eligible on whichever is later, the Effective Date or 60 days after date of enrollment.

If Your dependents are covered, they will be eligible when You are or as soon as they become dependents.

- Dependents are the Subscriber's Spouse and dependent children from birth to age 26.
- Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are covered.
- Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability (as defined in the New York Mental Hygiene Law), or physical disability and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child qualifies and continues to qualify under this section.
- If You have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New

York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

Enrollment Requirements

If You are paying all or a portion of premiums for Yourself or Your dependents then:

- You must enroll within 31 days after the date You become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If You elect dependent coverage, You must enroll all of Your covered Dependents for coverage.
- You must pay Premiums in the manner elected by the Group and approved by Us. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If You pay Premiums for Your Dependents, You must pay the Premiums in the manner elected by the Group and approved by Us until Your dependents are no longer eligible or until You choose to drop dependent coverage. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.
- A child who is eligible as a Subscriber and a Dependent can be insured under the Contract as a Subscriber or as a Dependent but not both at the same time.

SECTION V. CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the dental services described in Attachment B. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Group subject to receipt of such information from the Group or at the time a claim is submitted. Additional eligibility periods, if any, are listed in Attachment A. If You receive dental services from a Provider outside the state of New York, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

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

Member Coinsurance

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

The amount of Your Employee Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Employee Coinsurance for covered services. Your group has chosen to require Employee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Group and Employees.

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

Deductible

Your dental plan features a Deductible. This is an amount You must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in Attachment A. Deductibles apply to all Benefits unless otherwise noted.

Only the Provider's fees You pay for covered Benefits will count toward the Deductible.

Deductible Takeover allows any Deductible You incurred for services while covered under Your former group dental plan that was replaced by this dental plan to be credited towards satisfying the Deductible under this plan. This Benefit is listed in Attachment A.

Maximum Amount

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

Pre-Treatment Estimate

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

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

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

Medically Necessary

We Cover certain benefits described in this Certificate as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary (e.g. procedures such as laboratory processed crowns, periodontal surgical services, orthodontics, fixed prosthodontic services, and implant procedures). The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services that is at least as likely to produce equivalent therapeutic or diagnostic results.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

SECTION VI. EXCLUSIONS

No coverage is available under this Certificate for the following:

Cosmetic Services
We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect except for orthodontics as described in Attachment B. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Certificate unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for emergency dental care as described in Attachment B.

Experimental or Investigational Treatment
We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

Felony Participation
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

Government Facility
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

Medical Services
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

Medically Necessary
In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Certificate.

Medicare or Other Governmental Program
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

Military Service
We do not Cover an illness, treatment or medical condition due to service in the armed forces or auxiliary units.

No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services not Listed
We do not Cover services that are not listed in this Certificate as being Covered.

Services Provided by a Family Member
We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

Services Separately Billed by Hospital Employees
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge
We do not Cover services for which no charge is normally made.

War
We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION VII. SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support Your right to freedom of choice regarding Your Provider. This assures that You have full access to the dental treatment You need from the dental office of Your choice. You may see any Provider for Your covered treatment, whether the Provider is a PPO Provider, Premier Provider or a Non-Participating Provider. In addition, You and Your family members can see different Providers.

Remember, You enjoy the greatest Benefits—including out-of-pocket savings—when You choose a PPO Provider. To take full advantage of Your dental plan, we highly recommend You verify a dentist's participation status with Your dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of payment procedures to understand the method of payments applicable to Your dentist selection and how that may impact Your out-of-pocket costs.

Locating a Delta Dental PPO Provider

There are two ways in which You can locate a PPO Provider near You:

- You may access information through our website at deltadentalins.com. This website includes a Provider search function allowing You to locate PPO Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at 800-932-0783 and one of our representatives will assist You. We can provide You with information regarding a Provider's network, specialty and office location.

SECTION VIII. HOW CLAIMS ARE PAID

PAYMENT FOR SERVICES — PARTICIPATING PROVIDERS

PPO Provider

Payment for covered services performed for You by a PPO Provider is calculated based on the Maximum Contract Allowance. PPO Providers have agreed to accept the Delta Dental PPO Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Coinsurance shown in *Attachment A*. Our Payment is sent directly to the PPO Provider who submitted the claim. We advise You of any charges not payable by us for which You are responsible. These charges are generally Your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Premier Provider

Payment for covered services performed for You by a Premier Provider is calculated based on the Maximum Contract Allowance. Premier Providers have agreed to accept the Delta Dental Premier Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Coinsurance shown in *Attachment A*. Our Payment is sent directly to the Premier Provider who submitted the claim. We advise You of any charges not payable by us for which You are responsible. These charges are generally Your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

PAYMENT FOR SERVICES — NON-PARTICIPATING PROVIDER

Payment for services performed for You by a Non-Participating Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Coinsurance shown in *Attachment A*. Non-Participating Providers have no agreement with US and are free to bill You for any difference between what We pay and the Submitted Fee.

When dental services are received from a Non-Delta Dental Provider, Delta Dental's Payment is sent directly to the Primary Enrollee. You are responsible for payment of the Non-Delta Dental Provider's Submitted Fee. Non-Delta Dental Providers will bill You for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider Yourself and then submit a claim to us for reimbursement. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Coinsurance shown in *Attachment A*. Since our payment for services You receive may be less than the Non-Delta Dental Provider's actual charges, Your out-of-pocket cost may be significantly higher. We advise You of any charges not payable by us for which You are responsible. These charges are generally Your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

How to Submit a Claim

We do not require special claim forms. However, most dental offices have Claim Forms available. Participating Providers will fill out and submit Your claims paperwork for You. Some Non-Participating Providers may also provide this service upon Your request. If You receive services from a Non-Participating Provider who does not provide this service, You can submit Your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

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

Delta Dental of New York, Inc.
P.O. Box 2105
Mechanicsburg, PA 17055-2105

SECTION IX. CLAIM DETERMINATIONS

Claims

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

Notice of Claim

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Employee identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 800-471-0275 or visiting Our website at deltadentalins.com. Completed claim forms should be sent to the address in the How Claims Are Paid section of this Certificate. You may also submit a claim to Us electronically by sending it to deltappoclaims@delta.org or visiting Our website at deltadentalins.com.

Timeframe for Filing Claims

Claims for services must be submitted to Us for payment within 12 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 12-month period, You must submit it as soon as reasonably possible.

Claims for Prohibited Referrals

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

Claim Determinations

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

Pre-service Claim Determinations

- A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

  If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

- **Urgent Pre-service Reviews**

  With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

Post-service Claim Determinations

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

Payment of Claims

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION X. GRIEVANCE PROCEDURES

Grievances

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

Filing a Grievance

You can contact Us in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

Grievance Determination

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance.

Grievance Appeals

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

Assistance
If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XI. UTILIZATION REVIEW

Utilization Review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 800-471-0275. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical

condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call 800-471-0275 or visit Our website at deltadentalins.com.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if you want to receive electronic notifications. To opt into electronic notifications call 800-471-0275 or visit Our website at deltadentalins.com. You can opt out of electronic notifications at any time.

Preauthorization Reviews

- **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

  If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

- **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

Concurrent Reviews

- **Non-Urgent Concurrent Reviews.** Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

- **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

Retrospective Reviews

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Reconsideration

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer review if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

Standard Appeal

Preauthorization Appeal. If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Retrospective Appeal. If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeal. An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Full and Fair Review of an Appeal

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

Appeal Assistance

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400,

or email cha@cssny.org Website: www.communityhealthadvocates.org

SECTION XII. EXTERNAL APPEAL

Your Right to an External Appeal

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
  a) We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  b) You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  c) We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

Your Right to Appeal A Determination that A Service Is Not Medically Necessary

If We have denied coverage on the basis that the service does not meet Our requirements for Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph above.

Your Right to Appeal A Determination that A Service is Experimental or Investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph above and Your attending Physician must certify that Your condition or disease is one for which:

- Standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard service or procedure covered by Us; or
- There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

The External Appeal Process

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a

decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

Your Responsibilities

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XIII. COORDINATION OF BENEFITS

This section applies when You also have group dental coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

Definitions

- **"Allowable expense"** is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
- **"Plan"** is other group dental coverage with which We will coordinate benefits. The term "plan" includes:
  a) Group dental benefits and blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
  b) Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

c) Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

- **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
- **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to Determine Order of Payment

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

- If the other plan does not have a provision similar to this one, then the other plan will be primary.
- If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
- If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
- If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:
  a) The plan of the parent who has custody will be primary;
  b) If the parent with custody has remarried, and the child is also covered as a child under the step- parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
  c) If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
- If the person receiving services is covered under one plan as an active employee or member (i.e., not laid- off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
- If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

Our Right to Recover Overpayment

If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans

We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this Certificate is primary, as defined in this section, We will pay benefits first.
- If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
- If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XIV. TERMINATION OF COVERAGE

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

- The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
- The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
- Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
- For Spouses in cases of divorce, the date of the divorce.
- For Children, until the end of the month in which the Child turns 26 years of age.
- For all other Dependents, the date the Dependent ceases to be eligible.

- The end of the month following the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
- If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will termination for the Dependent.
- The date that the Group Contract is terminated. If We terminate and/or decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 30 days' prior written notice.
- The Group has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage.
- The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
- The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
- The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA or USERRA.

SECTION XV. EXTENSION OF BENEFITS

Upon termination of insurance, whether due to termination of eligibility, or termination of the Group Contract, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before Your coverage ended.

SECTION XVI. CONTINUATION OF COVERAGE

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

Qualifying Events

Pursuant to federal COBRA, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

- If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

- If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
  a) Voluntary or involuntary termination of the Subscriber's employment;
  b) Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
  c) Divorce or legal separation from the Subscriber;
  d) Death of the Subscriber; or
  e) The Covered employee becoming entitled to Medicare.
- If You are a covered Child, You may continue coverage if Your coverage ends due to:
  a) Voluntary or involuntary termination of the Subscriber's employment;
  b) Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
  c) Loss of covered Child status under the plan rules;
  d) Death of the Subscriber; or
  e) The covered employee becoming entitled to Medicare.

If You want to continue coverage You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:

- The date coverage would otherwise terminate; or
- The date You are sent notice by first class mail of the right of continuation by the Group. The Group may charge up to 102% of the Group Premium for continued coverage. Continued coverage under this section will terminate at the earliest of the following:
- The date 18 months after the Subscriber's coverage would have terminated because of termination of employment; provided that the Subscriber or their dependents may continue for a total of 29 months if the Employee is determined to be disabled under the United States Social Security Act.
- If You are a covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
- The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
- The date You become entitled to Medicare;
- The date to which Premiums are paid if You fail to make a timely payment; or
- The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

Continuation Rights During Active Duty

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), most employer- sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write Your Group to find out if You are entitled to temporary continuation of coverage under USERRA.

The Group may charge up to 102% of the Group Premium for continued coverage. This does not apply if You or Your dependents serve less than 31 days.

Continued coverage under this section will terminate at the earliest of the following:

- The 24-month period beginning on the date on which the absence begins; or
- The day after the date on which You or Your Dependent fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.

- This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
- If You or Your Dependent's coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former Employees of the uniformed services and their dependents, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if You or Your Dependents had become reemployed upon such termination of eligibility.

SECTION XVII. GENERAL PROVISIONS

Clinical Examination

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

Notice of Claim Form

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

To Whom Benefits Are Paid

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

Assignment

You cannot assign any benefits under this Certificate to any person, corporation, or other organization and any such assignment will be void and unenforceable. You cannot assign any monies due under this Certificate to any person, corporation or other organization. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services.

Recovery of Overpayments

On occasion a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

Right to Offset

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

Time to Sue

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

Conformity With Law

Any term of the Contract which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

Translation Services

Translation services are available free of charge under this Certificate for non-English speaking Employees. Please contact Us at 800-471-0275 to access these services.

Who May Change this Certificate

This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Operating Officer (“COO”) or a person designated by the COO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the COO or person designated by the COO.

Incontestability

No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

Fraud and Abusive Billing

We have processes to review claims before and after payment to detect fraud and abusive billing. Employees seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Furnishing Information and Audit

The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with certain information over the telephone for reasons such as following: to determine the level of care You need; so that We may certify care authorized by Your Provider, or make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

Significant Change in Circumstances

If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

Your Dental Records and Reports

In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your dental records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or Our designee permission to obtain and use Your dental records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a dental professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a dental professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your dental records by Us.

We agree to maintain Your dental information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

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.

We:

- Provide free aids and services to people with disabilities to communicate effectively with Us, such as:
    - Qualified sign language interpreter
    - 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 at 800-471-0275.

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

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 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.

Attachment A
Schedule of Benefits

Contractholder: Town of Riverhead

Group Number: 22980 **Effective Date:** September 1, 2024

Deductibles & Maximums	
Annual Deductible	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Deductibles waived for	Diagnostic & Preventive and Orthodontic Services
Deductible Takeover	Any annual Deductible amount satisfied by the Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.
Annual Maximum	$1,500 per Enrollee per Calendar Year
Annual Maximum waived for	Diagnostic and Preventive Services
Orthodontic Maximum	$1,500 per dependent child Enrollee to age 26 per lifetime
Maximum Takeover Credit	Delta Dental will receive credit for any amount paid under the Contractholder's previous dental care plan from January 1st to the Effective Date. These amounts will be credited towards the Annual Maximum. Delta Dental will receive credit for any amount paid under the Contractholder's previous dental care plan, if applicable, for Orthodontic Services. These amounts will be credited towards the maximum amounts payable for Orthodontic Services.

Enrollee Responsibility for Cost Sharing		
Dental Service Category	**In-Network Enrollee Responsibility for Cost Sharing when using Delta Dental PPO Providers†**	**Out-of-Network Coinsurance Enrollee Responsibility for Cost Sharing when using Delta Dental Premier and Non-Delta Dental Providers†**
The Enrollee Responsibility is shown in this table for the following services:		
Diagnostic and Preventive Services	0%	0%
Basic Services	20%	20%
Major Services	50%	50%
Orthodontic Services	50%	50%
TMJ Services	50%	50%

† Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and PPO Contracted Fees for Non-Delta Dental Providers.

ATTACHMENT B
SERVICES AND LIMITATIONS

The Enrollee Responsibility is shown in Attachment A for the following services:

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

- **Basic Services**
  - (1) Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care).
  - (2) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
  - (3) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (4) Periodontics: treatment of gums and bones supporting teeth.
  - (5) Palliative: emergency treatment to relieve pain.
  - (6) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
  - (7) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
  - (8) Specialist Consultations: opinion or advice requested by a general dentist.

- **Major Services**
  - (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
  - (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

- **Temporomandibular Joint (TMJ) Dysfunction Services**
  Intra-oral services provided by a Provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofacial pain dysfunction or malfunction of the temporomandibular (jaw) joint (TMJ).

- **Orthodontic Services**
  Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, We will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract 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 by the Enrollee or her Provider when the claim is submitted.

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) a crown where a filling would restore the tooth;
  b) an inlay/onlay instead of an amalgam restoration;
  c) 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
  d) an overdenture instead of denture.

- Exam and cleaning limitations:
  a) We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year.
  b) A full mouth debridement is allowed once in a lifetime when the Enrollee has 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 cleaning frequency in the year provided.
  c) Note that periodontal maintenances, Procedures Codes that include periodontal maintenances and full mouth debridement are covered under Basic Services and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
  d) Caries risk assessments are allowed once in 12 months.

- X-ray limitations:
  a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
  c) If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
  d) A complete intraoral series or panoramic film are limited to once every 60 months.
  e) Bitewing x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Employees age 18 and over. Unless warranted by special circumstances, bitewings of any type are disallowed within 12 months of a full mouth series.
  f) Bitewing x-rays are limited to two (2) images for Enrollees under age 10.
  g) Image capture procedures are not separately allowable services.

- Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice per Calendar Year.

- Interim caries arresting medicament application is limited to twice per tooth per Calendar Year.

- Space maintainer limitations:
  a) Space maintainers are limited to the initial appliance for Enrollees to age 14. However, a distal shoe space maintainer-fixed-unilateral is limited to children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
  b) Recementation of space maintainer is limited to once per lifetime.
  c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

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

- Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are covered. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.

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

- Specialist Consultations, screenings of patients and assessments of patients count toward the oral exam frequency.

- 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 Provider/Provider 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 up 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 Provider/Provider 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 to age 19.

- Retreatment of apical surgery by the same Provider/Provider 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 x-rays or select Diagnostic procedures.

- Periodontal limitations:
  a) 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. No more than two quadrants of scaling and root planing will be covered on the same date of service.
  b) 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 Provider/Provider office.
  c) 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.
  d) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
  e) 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 Provider office.
  f) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Service and are limited to once in a 24-month period.

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

- The following Oral Surgery procedure is limited to age 19 (or orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.

- The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.

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

- Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when We determine the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

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

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

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

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

- Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under Our programs 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 Enrollees age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under Our program will be made if We determine it is

unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for implant site per 60 months whether provided under Our program or any other dental care plan.

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

- Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

- We limit payment for dentures to a standard partial or complete denture (Employee Coinsurances apply). 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.
  a) 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.
  b) 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.
  c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
  d) Recementation of fixed partial dentures is limited to once in a lifetime.

- Limitations on Orthodontic Services:
  a) The maximum amount payable for each Enrollee is shown in Attachment A.
  b) Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.
  c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
  d) Benefits are not paid for orthodontic retreatment procedures.
  e) Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the orthodontic Enrollee Responsibility and maximum if covered as Benefits under Our standard processing policies.
  f) Benefits for Orthodontic Services are limited to dependent child Enrollees under the age of 26.

- Limitations on TMJ Services:
  a) TMJ Benefits are subject to all the limitations, exclusions and other terms and conditions under the Contract.
  b) We will not pay for the repair or replacement of any appliance furnished in whole or in part under this or any other health plan which provides TMJ Benefits.
  c) Benefits are limited to: those intra-oral services which would normally be provided by a Provider in relief of oral symptoms associated with TMJ and will not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
  d) Fixed appliances and restorations are excluded. Diagnostic procedures not otherwise covered under this plan are excluded.
  e) Any procedure paid under any other category of Benefits is not covered as a TMJ Benefit.
  f) We will not cover the repair of any appliances for Night Guard/Occlusal Guard or Temporary Tooth Stabilization Services. Adjustment of an occlusal orthotic device is allowed once in 12-months following six months from initial placement.

Attachment C
Wellness Benefits

Contractholder: Town of Riverhead

Group Number: 22980 **Effective Date:** September 1, 2024

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

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

Wellness Benefits
The information in the table below replaces the coverage for routine cleanings, periodontal maintenance and periodontal scaling and root planing described in Attachment B Services and Limitations.

Service	Enrollee Responsibility for Cost Sharing with PPO Providers	Enrollee Responsibility for Cost Sharing with Premier and Non-Delta Dental Providers	Limitations
Routine Cleaning & Periodontal Maintenance[1]	100%	100%	any combination of four (4) each Calendar Year
Periodontal Scaling & Root Planing	100%	100%	once every Calendar Year per quadrant with no more than two (2) quadrants covered on the same date of service.

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

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

Signing up for Wellness Benefits

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

Sign up by phone
Call 800-932-0783 to speak to a Customer Services Representative during regular business hours.

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)