

EMPLOYEE BENEFIT BOOKLET

PAYPAL, INC.



deltadentalins.com

Group No: 17690

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INTRODUCTION

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

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

Using This Employee Benefit Booklet

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

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

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

Contact Us

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

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

DELTA DENTAL OF CALIFORNIA
560 Mission Street
Suite 1300
San Francisco, CA 94105

DEFINITIONS

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

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

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

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

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

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

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

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

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

Covered Service: the services for which covered benefits are available under the Plan.

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

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

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

Delta Dental PPOSM Provider (PPO Provider): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee contracted fees 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.

Dental Emergency: Dental screening, examination, and evaluation by a Provider, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Provider, to determine if an emergency dental condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency dental condition, within the capability of the facility.

Dental Emergency Condition: a dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in: 1) placing the Enrollee's health in serious jeopardy; 2) causing other serious dental or health consequences, and/or 3) causing serious impairment of dental functionality.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

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

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

Eligible Employee: any employee as eligible for Benefits.

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

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

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

Maximum: is the maximum dollar amount ("Maximum Amount" or "Maximum") Delta Dental will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. Delta Dental will pay the Maximum Amount(s), if applicable, shown in Attachment A for Benefits under the Contract.

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

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

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

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

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

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

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

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

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

Qualifying Status Change: subject to the terms and conditions of the cafeteria plan sponsored by PayPal, generally means a change in:

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

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

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

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

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

COST OF COVERAGE

You are currently required to contribute toward the cost of your coverage.

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

Before you decide to enroll in the dental plan, PayPal informs you of the amounts you must contribute for coverage under the dental plan in enrollment materials and other communications. For information on the contribution amounts, please contact a member of the PayPal benefits team. PayPal reserves the right to amend and modify the amount of employer and employee contributions at any time.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements

See your PayPal, Inc. Health and Welfare Benefits Plan Summary Plan Description ("PayPal SPD") for eligibility information. The PayPal SPD also has information regarding enrollment requirements, loss of eligibility (termination of coverage), continuation of benefits, leaves of absence, USERRA, and COBRA.

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 will be processed in accordance with our standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards. Delta Dental will provide advance notice of such changes to the Contractholder who will then distribute to Primary Enrollees.

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

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

Enrollee Coinsurance

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

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

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

Deductible

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

Maximum Amount

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

Pre-Treatment Estimate

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

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

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

Coordination of Benefits

We coordinate the Benefits under the Contract with your benefits under any other group health plan, insurance policy, or pre-paid plan designed to fully integrate with other policies. Benefits under this Plan may be reduced so that combined coverage does not exceed our portion of the Maximum Contract Allowance. If this plan is the "primary" plan, we will not reduce Benefits, but if this plan is the "secondary" plan, we determine Benefits after those of the primary plan and will pay the lesser of the amount that we would pay in the absence of any other dental benefit coverage or the Enrollee's total out-of-pocket cost under the primary plan for Benefits covered under the Contract.

- How do we determine which plan is the "primary" program?
 - (1) The plan covering you as an employee is primary over a plan covering you as a dependent.
 - (2) The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a) secondary to the plan covering the insured person as a dependent and
 - b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
 - (3) Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
 - a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
 - b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

SELECTING YOUR PROVIDER

Free Choice of Provider

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

Locating a PPO Provider

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

Choosing a PPO Provider

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

Choosing a Premier Provider

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

Choosing a Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO or Premier Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-

Delta Dental Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Provider's Submitted Fee.

Additional Obligations of PPO and Premier Providers

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

How to Submit a Claim

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

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

DELTA DENTAL OF CALIFORNIA
P.O. Box 997330
Sacramento, CA 95899-7339

Payment Guidelines

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

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

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

Provider Relationships

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

CLAIMS AND APPEALS

Your authorized representative may act on your behalf to pursue claims and appeals. In the case of a claim involving urgent care, a health care professional with knowledge of the claimant's medical condition is permitted to act as the claimant's authorized representative. For more information regarding authorized representatives, please contact 800-632-8555.

Timing of Claim Decision

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

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

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

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

(A) Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. We will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

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

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

Notice of Claim Denial

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

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

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

TIMING OF APPEAL

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

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

DELTA DENTAL OF CALIFORNIA
Customer Service Department
PO Box 997330
Sacramento, CA 95899-7330
Phone Number: 1-800-765-6003

Review of Appeal

For appeals of post-service claims we will send you a written acknowledgment within sixty (60) days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered in the initial claim determination. The review will be conducted for us by an appropriately named fiduciary who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The review does not afford deference to the initial adverse benefit determination.

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

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

Notice of Appeal Decision

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

1. The specific reason(s) for the denial;
2. Specific references to the pertinent Plan provisions on which the denial is based;
3. Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits;
4. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures;
5. Your right to bring a civil action under ERISA Section 502(a) after completion of all required levels of review;
6. If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a notice of where and how you can obtain a copy free of charge upon request;

7. If your claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request; and
8. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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

If the Enrollee believes he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Non-Discrimination

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

Delta Dental:

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

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

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

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

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

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

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

Clinical Examination

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

Notice of Claim Form

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

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

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

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

Time of Payment

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

To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you. All Benefits not paid to 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.

Misstatements on Application: Effect

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

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

Legal Actions

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

Attachment A
Deductibles, Maximums and Contract Benefit Levels
Core Plan

Deductibles & Maximums		
	Delta Dental PPO Providers[†]	Delta Dental Premier and Non-Delta Dental Providers[†]
Annual Deductible	\$50 per Enrollee each Calendar Year \$150 per family each Calendar Year	\$75 per Enrollee each Calendar Year \$225 per family each Calendar Year
	If an Enrollee switches between types of Providers during a Calendar Year, the maximum Deductible you will be responsible for is \$75 per Enrollee and \$225 per family.	
Deductibles waived for	Diagnostic & Preventive Services	
	If an Enrollee switches from the Enhanced Plan to the Core Plan at Open Enrollment, the Maximum Deductible(s) the Enrollee will be responsible for will not exceed the applicable Deductible(s) for the Core Plan.	
Annual Maximum	\$1,500 per Enrollee per Calendar Year	
Annual Maximum waived for	Diagnostic & Preventive Services	
	If an Enrollee switches from the Enhanced Plan to the Core Plan during the Calendar Year, the Annual Maximum will not exceed the applicable Annual Maximum for the Core Plan.	
Nightguard Maximum	\$500 per Enrollee once every two Calendar Years	

Contract Benefit Levels		
Dental Service Category	Delta Dental PPO Providers[†]	Delta Dental Premier and Non-Delta Dental Providers[†]
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown below for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%

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

Enhanced Plan

Deductibles & Maximums		
	Delta Dental PPO Providers[†]	Delta Dental Premier and Non-Delta Dental Providers[†]
Annual Deductible	\$0	\$50 per Enrollee each Calendar Year \$150 per family each Calendar Year
Deductibles waived for	None	Diagnostic & Preventive and Orthodontic Services
	If an Enrollee switches from the Core Plan to the Enhanced Plan at Open Enrollment, the Maximum Deductible(s) the Enrollee will be responsible for will not exceed the applicable Deductible(s) for the Enhanced Plan.	
Annual Maximum	\$2,500 per Enrollee per Calendar Year	
Annual Maximum waived for	Diagnostic & Preventive Services	
	If an Enrollee switches from the Core Plan to the Enhanced Plan during the Calendar Year, the Annual Maximum will not exceed the applicable Annual Maximum for the Enhanced Plan.	
Nightguard Maximum	\$500 per Enrollee once every two Calendar Years	
Lifetime Orthodontic Maximum	\$2,500 per Enrollee	
Maximum Takeover Credit	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 lifetime maximum amounts payable for Orthodontic Services.	

Contract Benefit Levels		
Dental Service Category	Delta Dental PPO Providers[†]	Delta Dental Premier and Non-Delta Dental Providers[†]
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown below for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Orthodontic Services	50%	50%

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

Attachment B Services, Limitations and Exclusions

Description of Dental Services

Delta Dental will pay the Contract Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

- | | | |
|-----|---------------------------|--|
| (1) | Diagnostic: | procedures to aid the Provider in determining required dental treatment, including x-rays. |
| (2) | Preventive: | cleaning (including scaling in the 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) | Palliative: | emergency treatment to relieve pain. |
| (4) | Specialist Consultations: | opinion or advice requested by a general dentist. |
| (5) | Professional Visits: | visit to a Provider for observation or after regularly scheduled hours. |

- **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) | Sealants: | topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay. |
| (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) | Night Guard/Occlusal Guard: | intraoral removable appliances provided for treatment of harmful oral habits associated with periodontal disease. |
| (8) | Denture Repairs: | repair to partial or complete dentures, including rebase procedures and relining. |
| (9) | Adjunctive General Services | therapeutic drug injection when performed on the same day as an extraction; treatment of post-surgical complications (unusual circumstances); limited occlusal adjustment |

- **Major Services**

- | | | |
|-----|--|---|
| (1) | Crowns and Inlays/Onlays, and Cast Restorations: | 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 re cementation.

- **Orthodontic Services (Applicable to the Enhanced Plan only)**

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

Limitations below with age limitations will be subject to exception based on medical necessity.

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

Examples of Optional Services:

- a) A crown where a filling would restore the tooth;
- b) An inlay or porcelain/ceramic onlay instead of an amalgam restoration; or
- 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).

2. Delta Dental will pay for oral examinations, including specialist consultations, (except after hour exams and exams for observation), and cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than three times in a Calendar Year; and topical application of fluoride solutions no more than twice in a Calendar Year. A full-mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full-mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy. Patients with diabetes are eligible for one additional cleaning during the Calendar Year. Refer to SmileWay Wellness Benefits at the end of this book.

3. X-ray limitations:

- a) Delta Dental will limit the total reimbursable amount to the Delta Dental Dentist'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), Delta Dental will limit the total reimbursable amount to the Delta Dental Dentist's accepted fee for a complete intraoral series.
- c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
- d) A complete intraoral series and panoramic film are each limited to once every five (5) years.
- e) Bitewing x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full-mouth series unless warranted by special circumstances.

4. Diagnostic casts are a Benefit only when made in connection with subsequent orthodontic treatment covered under this plan.

5. Sealant Benefits include the application of sealants only to permanent first molars up to age nine and second molars to age 16 if they are without caries (decay), or restoration on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.
6. Space maintainer limitations:
 - a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee through age 12.
 - b) Recementation of a 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 Dentist's office.
7. Pulp vitality tests are allowed once per day when definitive treatment is not performed.
8. Cephalometric x-rays, oral/facial photographic images (once per lifetime) and diagnostic casts (once per lifetime) are covered to age 19.
9. Screenings of patients and assessments of patients are limited to once in a lifetime per Dentist and count toward the oral exam frequency.
10. Delta Dental will not cover to replace an amalgam, synthetic porcelain or plastic restoration (fillings) or prefabricated resin and stainless steel crowns within 24 months of treatment if the service is provided by the same Dentist office. Replacement restorations within 24 months are included in the fee for the original restoration.
11. Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
12. Delta Dental limits payment for prefabricated resin crowns under this section to services on baby (deciduous) teeth. Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16.
13. Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only.
14. Root canal therapy and pupal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Dentist/Dentist office within 24 months is considered part of the original procedure.
15. 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.
16. Retreatment of apical surgery by the Dentist/Dentist office within 24 months is considered part of the original procedure.
17. When allowed, retrograde fillings per root are limited to once in any 24-month period.
18. When allowed, root amputation per root and/or hemisection is limited to once in a lifetime.
19. Pin retention is covered not more than once in any 24-month period.
20. 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.
21. 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.
 - 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.

- 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 periradicular surgery, ridge augmentation or implants.
 - d) If in the same quadrant, scaling and root planing must be performed at least six weeks prior to the periodontal surgery.
 - 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 Dentist.
22. Limitations on Night Guard/Occlusal Guard Services:
- a) The replacement of appliances for Night Guard/Occlusal Guard Services is limited to once every 24 months.
 - b) Night Guard/Occlusal Guard adjustment is allowed once in a 12-month period following six (6) months from the initial placement.
 - c) The maximum amount Delta Dental will pay for Night Guards/Occlusal Guards provided to any Enrollee is \$500 once every two Calendar Years.
23. Covered oral surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures which are covered once in the same day.
24. Accession of tissue procedures and/or accession of exfoliative cytologic smears are allowed once in the same day. If more than one of these procedures is billed on the same day, for the same site, and by the same Dentist/Dentist office, Delta Dental will only pay for the most inclusive procedure.
25. The following oral surgery procedure is limited to age 19: transseptal fiberotomy/supra crestal fiberotomy, by report.
26. The following oral surgery services are limited to age 19 (or ortho limiting age) provided orthodontics are covered; surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, surgical repositioning of teeth.
27. Crowns and onlays are limited to Enrollees age 12 and older and are covered not more often than once in any five (5) year period except when Delta Dental determines the existing crown or 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.
28. When an alternate Benefit of an amalgam is allowed for inlays or porcelain/ceramic onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any five (5) year period.
29. Core buildup, including any pins, are covered not more than once in any five (5) year period.
30. Post and core services are covered not more than once in any five (5) year period.
31. Crown repairs are covered not more than once in any five (5) year period.
32. When allowed within six months of a restoration, the Benefit for a crown, inlay/onlay, or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
33. Denture repairs are covered not more than once in any six-month period except for fixed denture repairs which are covered not more than once in any five (5) year period.
34. Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing 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 a Delta Dental program will be

made if Delta Dental determines 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. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.

35. 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.
36. Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Dentist/Dentist office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Dentist/Dentist office.
37. Delta Dental limits payment for dentures to a standard partial or denture (Enrollee 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.
38. A labial veneer performed chairside is covered once in a 24-month period. A laboratory processed labial veneer is covered once every five (5) years. Labial veneers are generally considered cosmetic services. A single labial veneer may be authorized if the tooth meets the criteria for a laboratory processed crown. If a veneer is allowed, a repair is considered included in the original fee for the first 24 months and denied thereafter.
39. Limitations on Orthodontic Services (**Applicable to the Enhanced Plan only**)
 - a) Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.
 - b) Benefits are not paid to repair or replace any orthodontic appliance received under this program.
 - c) Benefits are not paid for orthodontic retreatment procedures.
 - d) Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the orthodontic Contract Benefit level and Maximum if covered as Benefits under Delta Dental's standard processing policies.
 - e) X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.

Exclusions

Exclusions below with age limitations will be subject to exception based on medical necessity.

We do not pay Benefits for:

1. Treatment of injuries or illness covered under Workers' Compensation or Employer's Liability Laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
2. Cosmetic surgery or procedures for purely cosmetic reasons.
3. Provisional and/or temporary restorations except an interim removable partial denture is covered only to replace extracted anterior permanent teeth during the healing period.

4. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development) fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
5. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and is not a covered Benefit.
6. Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards and abfraction.
7. Any Single Procedure provided prior to the date the Enrollee became eligible for services under this program.
8. Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
9. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
10. Charges for anesthesia, other than general anesthesia and I.V. sedation administered by a licensed Dentist in connection with covered Oral Surgery or selected Endodontic and Periodontic procedures.
11. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").
12. Laboratory processed crowns for Enrollees under age 12.
13. Fixed bridges and removable partials for Enrollees under age 16.
14. Interim implants.
15. Indirectly fabricated resin-based inlays and onlays.
16. Overdentures.
17. Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
18. Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broker appointments.
19. Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
20. Services or supplies covered by any other health plan of the Contractholder.
21. Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
22. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
23. Deductibles, amounts over plan Maximums and/or any service not covered under the dental plan.

24. Services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
25. Services for any disturbance of the temporomandibular (jaw) joints or associated musculature, nerves and other tissues (TMJ).
26. Replacement of existing restoration for any purpose other than active tooth decay.
27. Complete occlusal adjustment.

Attachment C SmileWay Wellness Benefits

Contractholder: PayPal, Inc.

Group Number: 17690 **Effective Date:** January 1, 2024

SmileWay Wellness Benefits (“Wellness Benefits”) are available to help improve the oral health of Enrollees with certain Qualifying Medical Conditions.

Qualifying Medical Conditions

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

Wellness Benefits

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

Service	PPO Providers’ Contract Benefit Level	Premier and Non-Delta Dental Providers’ Contract Benefit Level	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.

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

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

Signing up for Wellness Benefits

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