Delta Dental Insurance Company

EVIDENCE OF COVERAGE

Mississippi State University

Group No: 01125

Effective Date: January 1, 2024

Underwritten and administered by:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

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

Introduction

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

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

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

Identification ("ID") Card

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

Contract

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

Contact Us

For more information, visit Our website at deltadentalins.com or call Our Customer Service Center at 800-521-2651 or You may submit an inquiry to:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Michael G. Hankinson, Esq.
President

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

- the Spouse;
- dependent children from birth to age 26;
- as otherwise required by state or federal law.

Children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder.

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

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

Grace Period: a period of no less than 31 days for the payment of each Premium after the first Premium payment is due. Your coverage will continue in force during this period, subject to payment by the end of the Grace Period.

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

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

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

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

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

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

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

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

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

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

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

Program Allowance: the amount determined by an established level of all charges for services by Dentists with similar professional standing in the same geographical area. Program Allowances may be different based on the Dentist's contracting status.

Spouse: an individual who is a partner of the Primary Enrollee as:
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; or
- May be recognized by the Contractholder.

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

Eligibility and Enrollment – When Coverage Begins

Eligibility Requirements

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

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

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

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

Overage Children

An overage Dependent child may be eligible if:
- The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
- The child is chiefly dependent on the Primary Enrollee for support; and

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

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

If You are responsible for Your Premium,

- You must enroll within 31 days after the date You become eligible or during an Open Enrollment Period.

- All Dependents must be enrolled within 60 days after they become eligible or during an Open Enrollment Period or *Special Enrollment Period*.

- If You elect Dependent coverage, You must enroll all Your Dependent Enrollees for coverage.

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

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

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

Special Enrollment Periods – Enrollment Changes
After Your Effective Date, You may change Your enrollment during an Open Enrollment Period or during a *Special Enrollment Period* as a result of a qualifying status change. Qualifying status changes include, but are not limited to, the following events:
- Marital status Examples include, but are not limited to: marriage, divorce, legal separation, annulment or death;
- Number of Dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a stepchild or foster child, child under legal guardianship or other court order or death of a child);
- Dependent child ceases to satisfy eligibility requirements;
- Employment status (change in Your or Your Dependent's employment status);
- Residence (You move);
- Court order requiring Dependent coverage;
- Loss of other group coverage;
- Any other current or future election changes permitted by Internal Revenue Code Section 125; or
- Any other changes specified by applicable law or regulation.

Continuation of Benefits
We will not pay for any services/treatment received after Your coverage ends. However, We will pay for covered services incurred while You were eligible if the procedures are completed within 31 days of the date Your coverage ends. A dental service is incurred for:
- an appliance (or change to an appliance), at the time the impression is made;
- a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- root canal therapy, at the time the pulp chamber is opened; and
- all other dental services, at the time the service is performed, or the supply furnished.

Premiums

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

How To Use This Plan

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

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

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

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

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

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

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

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

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

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

Selecting Your Dentist – Free Choice of Dentist

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

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

Locating a PPO Dentist

To locate a PPO Dentist, You may access information through Our website at deltadentalins.com or contact Our Customer Service Center at 800-521-2651.

How Claims are Paid

PPO Dentist – Payment for Services

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

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

Premier Dentist – Payment for Services

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

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

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

When seeking services from a Premier Dentist, You are encouraged to review the *Attachment A* to verify the Dentist's in-network status or contact Our Customer Service Center at 800-521-2651 for assistance.

Non-Delta Dental Dentist - Payment for Services

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

A Non-Delta Dental Dentist can bill You the difference between the Dentist's Submitted Fee and the amount paid by Us unless Benefits are assigned in accordance with the Payment of Claims provision.

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

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

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

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

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

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

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

Time of Payment of Claims
All Benefits payable under this Contract for any loss, other than loss for which this Contract provides any periodic payment, will be paid within 25 days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within 25 days or 35 days, whichever is applicable, after We receive a clean claim containing necessary medical information and other information essential for Us to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by Us for adjudication and which requires no further information, adjustment or alteration by the Dentist of the services or You in order to be processed and paid by Us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to Us, do not change the clean claim status.

A clean claim does not include any of the following:

- A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim;
- Claims which are submitted fraudulently or that are based upon material misrepresentations;
- Claims that require information essential for Us to administer preexisting condition, coordination of benefits or subrogation provisions; or

- Claims submitted by a Dentist more than 30 days after the date of service; if the Dentist does not submit the claim on Your behalf, then a claim is not clean when submitted more than 30 days after the date of billing by the Dentist to You.

Not later than 25 days after the date We actually receive an electronic claim, We will pay the appropriate Benefit in full, or any portion of the claim that is clean, and notify the Dentist (where the claim is owed to the Dentist) or You (where the claim is owed to You) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date We actually receive a paper claim, We will pay the appropriate Benefit in full, or any portion of the claim that is clean, and notify the Dentist (where the claim is owed to the Dentist) or You (where the claim is owed to You) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us will be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that We will either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate Benefit due the Dentist (where the claim is owed to the Dentist) or You (where the claim is owed to You). To calculate the extent to which any Benefits are overdue, payment will be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the Dentist (where the claim is owed to the Dentist) or You (where the claim is owed to You) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the Dentist or You.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, We must pay the Dentist (where the claim is owed to the Dentist) or You (where the claim is owed to You) interest on accrued Benefits at the rate of 3% per month accruing from the day after payment was due on the amount of the Benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than $1.00, such amount will be credited to the account of the person or entity to whom such amount is owed.

In the event We fail to pay Benefits when due, the person entitled to such Benefits may bring action to recover such Benefits, any interest which may accrue as provided above and any other damages as may be allowable by law. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay Benefits and/or claims when due, the person entitled to such Benefits (Dentist or You) will be entitled to recover damages in an amount up to 3 times the amount of the Benefits that remain unpaid until the claim is finally settled or adjudicated.

Payment of Claims
Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity is payable to Your estate. Any other accrued indemnities unpaid at Your death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to You.

If You provide Us with written direction that all or a portion of any indemnities or Benefits provided by the Contract be paid to a licensed Dentist rendering services, then We will pay directly the licensed Dentist rendering such services. That payment will be considered payment in full to the Dentist, who may not bill or collect from You any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by You that are noncovered benefits. Any dispute between a Dentist and You arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance.

All Benefits not paid to the Dentist will be payable to You as the Primary Enrollee, or Dependent Enrollee, or to the estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian, or to any relative by blood or connection by marriage of the individual who is considered by Us to be equitably entitled to the Benefit, up to an amount not exceeding $1,000.

Enrollee Complaint Procedure
We will notify You and Your Dentist if Benefits are denied for services, in whole or in part, stating the reason(s) for denial. You have at least 180 days after receiving a notice of denial to request a complaint or appeal by telephone or in writing, giving reasons why You believe the denial was wrong or the nature of Your complaint. You and Your Dentist may also ask Us to examine any additional information provided that may support Your request.

If You have a complaint regarding eligibility, the denial of dental services or claims, Our policies, procedures or operations, or the quality of dental services performed by a Dentist, You may contact Our Customer Service Center at 800-521-2651 or submit a written complaint or appeal to:

Delta Dental Insurance Company
P.O. Box 1860
Alpharetta, GA 30023

Requests may also be made online via Our website at deltadentalins.com. We will send You a written acknowledgment within five (5) days of receipt of the appeal. We will make a full and fair review and may ask for more documents during this review if needed. The review will consider all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment, or clinical judgment in applying the terms of the Plan, We will consult with a Dentist who has appropriate training and experience. The review will be conducted by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. We will send You a decision within 30 days after receipt of Your appeal.

If You believe You need further review of Your appeal, You may contact Your state regulatory agency if applicable. If the group health Plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), You may contact the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") for further review of the claim or if You have questions about the rights under ERISA. You may also bring a civil action under Section 502(a) of ERISA.

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

Coordination of Benefits
If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, Benefits will be coordinated. If this Plan is the "primary" plan, We will not reduce Benefits. If this Plan is the "secondary" plan, We may reduce Benefits so that the total Benefits paid or provided by all plans do not exceed 100% of total allowable expense.

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

Other policies do not include Medicaid, hospital daily indemnity plans, specified diseases only policies, or limited occurrence policies that provide only for intensive or coronary care at a hospital, first aid outpatient medical expenses resulting from accidents, or specified accidents such as travel accidents.

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

- The plan covering You as a Primary Enrollee is primary over a plan covering You as a Dependent.
- The plan covering You as an employee is primary over a plan covering You as a Dependent; except that if You are also a Medicare beneficiary, and because of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - Secondary to the plan covering You as a Dependent; and
  - Primary to the plan covering You as other than a Dependent (i.e., a retired employee), then the Benefits of the plan covering You as a Dependent are determined before those of the plan covering You as other than a Dependent.

- Except as stated above, when this Plan and another plan cover the same child as a Dependent of different persons, referred to as parents:
  - The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
  - If both parents have the same birthday, the Benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period.
  - However, if the other plan has no birthday rule, but has a rule based on the gender of the parent, and as a result, the plans do not agree on the order of Benefits, the rule in the other plan determines the order of Benefits.

- In the case of a Dependent child of legally separated or divorced parents, the plan covering the child as a Dependent of the parent with legal custody or as a Dependent of the custodial parent's Spouse (i.e., stepparent) will be primary over the plan covering the child as a Dependent of the parent without legal custody.

- If there is a court decree establishing financial responsibility for the child's health care expenses, the Benefits of a plan covering the child as a Dependent of the parent with financial responsibility will be determined before the Benefits of any other policy covering the child as a Dependent child.

- If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child will follow the order of Benefit determination rules outlined above.

- The Benefits of a plan covering You as an employee, if applicable, who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same holds true if You are a Dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.

- If Your coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.

  - First, the Benefits of a plan covering You as an employee, if applicable, or Primary Enrollee (or the Primary Enrollee's Dependent).
  - Second, the Benefits under the continuation coverage.

    If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

- If none of the above rules determines the order of Benefits, the Benefits of the plan covering You as an employee longer are determined before those of the plan covering You for the shorter term.

- When determination cannot be made in accordance with the rules above, the Benefits of a plan that is a medical plan covering dental as a Benefit will be primary to a standalone dental plan.

Renewal and Termination of Benefits

This Plan renews on the anniversary of the Contract unless We provide notice of a change in Premiums or Benefits and the Contractholder does not accept the change. Your Benefits will terminate:
- As of the date this Plan is terminated,
- You cease to be eligible under the terms of this Plan, or
- Your enrollment is canceled under the terms of this Plan.

We are not obligated to continue to provide Benefits to You or Your Dependents except for completion of dental treatment started when this Plan was in effect.

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

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

Upon 15 days written notice if:
- The Premiums are not paid by, or on behalf of You, on the date due. However, You may continue to receive Benefits during the Grace Period and may be reinstated during the term of the Contract upon payment of any unpaid Premium; or
- You knowingly commit or permit another person to commit fraud or deception in obtaining Benefits.

Upon 30 days written notice if:
- The Contract is terminated or not renewed; or
- You fail to pay Coinsurances and/or Deductibles, if applicable. However, You may be reinstated during the term of the Contract upon payment of all delinquent charges.

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

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

General Provisions

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

Compliance with Administrative Simplification, Security and Privacy Regulations
The parties will comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable information including executing any agreements as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The parties agree that the Contract will incorporate terms as necessary and as applicable to execute the required agreements (i.e., business associate agreement) to comply with federal regulations issued under the HIPAA and Health Information Technology for Economic and Clinical Health ("HITECH") Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

Continued Coverage under USERRA
As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if You are covered on the date Your USERRA leave of absence begins, You may continue dental coverage for Yourself and any Dependents, if applicable. Continuation of coverage under USERRA may not extend beyond the earlier of:
- Twenty-four (24) months, beginning on the date the leave of absence begins, or;
- The date You fail to return to work within the time required by USERRA.

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

Continuation of Coverage Under COBRA
The federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides a way for You and Your Dependents, if applicable, who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See Your Human Resources Department or website for complete information. We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

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

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

No claims for loss incurred or disability commencing after two (2) years from the date of issue of the Contract will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of the Contract.

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

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

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

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

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

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

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

We:

- Provide free aids and services to people with disabilities to communicate effectively with Us, such as:
  - Qualified sign language interpreters;
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters;
  - Information written in other languages.

If You need these services, contact Our Customer Service Center at 800-521-2651.

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

Delta Dental
P.O. Box 997100
Sacramento, CA 95899
Telephone Number: 800-471-0236
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.

NOTICE OF PROTECTION PROVIDED BY MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in net cash surrender and net cash withdrawal values

Health Insurance
- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in Miss. Code Ann. § 83-23-209 and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

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

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract will be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org, or contact:

Mississippi Life and Health Insurance Guaranty Association
330 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755

Mississippi Insurance Department
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.

Attachment A
Deductibles, Maximums and Contract Benefit Levels

Contractholder: Mississippi State University

Group Number: 01125 **Effective Date:** January 1, 2024

Deductibles & Maximums		
Dental Service Category	**High Plan**	**Low Plan**
Annual Deductible	$50 per Enrollee each Calendar Year $150 per family each Calendar Year	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Deductibles waived for	Diagnostic & Preventive and Orthodontic Services	Diagnostic & Preventive 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.	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	$1,000 per Enrollee per Calendar Year
	If an Enrollee switches from the Low Plan to the High Plan during the Calendar Year, the Annual Maximum will not exceed the applicable Annual Maximum for the High Plan.	If an Enrollee switches from the High Plan to the Low Plan during the Calendar Year, the Annual Maximum will not exceed the applicable Annual Maximum for the Low Plan.
Orthodontic Maximum	$1,200 per dependent child Enrollee to age 26 per lifetime	Not Applicable
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 Maximum Amounts payable for Orthodontic Services.	Not Applicable

Contract Benefit Levels				
	High Plan		Low Plan	
Dental Service Category	**Delta Dental PPO℠ Providers†**	**Delta Dental Premier and Non-Delta Dental Providers†**	**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%	100%	100%
Basic Services	80%	80%	50%	50%
Major Services	50%	50%	25%	25%
Orthodontic Services	50%	50%	Not Covered	

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

Waiting Periods:

- Restorative, Endodontics, Periodontics, and Prosthodontics are limited to Enrollees who have been enrolled in the Contract for 12 consecutive months. Waiting periods for Dependent Enrollees are determined by the Primary Enrollee's length of coverage and are calculated for a Primary Enrollee and his/her Dependent Enrollee from the Primary Enrollee's Effective Date of Coverage as reported by the Contractholder.

- *Applicable to the High Plan only*
  Orthodontic Services are limited to dependent children of Primary Enrollees who have been enrolled in the Contract for 12 consecutive months. Waiting periods for Dependent Enrollees are determined by the Primary Enrollee's length of coverage and are calculated for a Primary Enrollee and his/her Dependent Enrollee from the Primary Enrollee's Effective Date of Coverage as reported by the Contractholder.

Attachment B
Services, Limitations and Exclusions

Contractholder: Mississippi State University

Group Number: 01125 **Effective Date:** January 1, 2024

Description of Dental Services
We 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.
  - (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 Major Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
  - (3) Specialist Consultations: opinion or advice requested by a general dentist.
- **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) Palliative: emergency treatment to relieve pain.
  - (4) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
  - (5) 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).
  - (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- **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.
  - (3) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (4) Periodontics: treatment of gums and bones supporting teeth.
- **Orthodontic Services (Applicable to the High 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

(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/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.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Exam and cleaning limitations:
a) We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in the 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 maintenance frequency in the year provided.
c) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
d) Note that periodontal maintenance, Procedure Codes that include periodontal maintenance and full mouth debridement are covered as a Major Benefit and that routine cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
e) Caries risk assessments are allowed once in 36 months.

(3) 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 and panoramic film are each 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 Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
f) Bitewing x-rays are limited to two images for Enrollees under age 10.
g) Image capture procedures are not separately allowable services.

(4) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.

(5) Interim caries arresting medicament application is limited to twice per tooth per Calendar Year.

(6) Space maintainer limitations:
   a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee 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) 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.

(7) Pulp vitality tests are allowed once in a 6-month period when definitive treatment is not performed.

(8) *Applicable to the High Plan only*
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 a covered benefit. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.

(9) Sealants are limited as follows:
   a) through age 15 on permanent 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.

(10) Specialist Consultations are limited to two within a calendar year per Provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered are limited to only one in a 12-month period and included if reported with any other examination on the same date of service and Provider office.

(11) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) 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.

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

(13) 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.

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

(15) 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.

(16) 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, one (1) interim visit and one (1) final visit to age 19.

(17) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(18) 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.

(19) 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.

(20) 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.

(21) *Applicable to the High Plan only*
The following Oral Surgery procedure is limited to age 26 (or orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.

(22) *Applicable to the High Plan only*
The following Oral Surgery procedures are limited to age 26 (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.

(23) 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).

(24) 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.

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

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

(27) Crown repairs are covered not more than once in any 6-month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.

(28) Denture Repairs are covered not more than once in any 24-month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(29) Prosthodontic appliances that were provided under any Delta Dental program 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 not provided under a Delta Dental program will be made if We determine it is unsatisfactory and cannot be made satisfactory.

(30) 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.

(31) 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.

(32) We limit payment for dentures to a standard partial or complete 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 one (1) per arch in a 6-month period and relining is limited to one (1) per arch in a six (6) month period.

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

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

(34) *Applicable to the High Plan only*
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) Benefits for Orthodontic Services are limited to dependent child Enrollees under the age of 26.
f) Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
g) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

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

Exclusions

We do not pay Benefits for:

(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(5) 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.

(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, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) fixed bridges and removable partials for Enrollees under age 16.

(12) interim implants, endodontic endosseous implant and Extraoral implants.

(13) indirectly fabricated resin-based Inlays/Onlays.

(14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(16) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening or tobacco counseling.

(17) 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.

(18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(19) 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.

(20) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(21) 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.

(22) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.

(23) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.

(24) missed and/or cancelled appointments.

(25) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(26) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(27) dental case management motivational interviewing and patient education to improve oral health literacy.

(28) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(29) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(30) diabetes testing.

(31) corticotomy (specialized oral surgery procedure associated with orthodontics).

(32) Antigen or antibody testing.

(33) counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use.

(34) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.

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)