DENTAL BENEFITS ADDENDUM

CENTRAL HEALTH MEDICARE PLAN

Plan A – EAE DSNP

23043

Effective Date: January 1, 2025

Counties:
Los Angeles, Riverside, Sacramento, San Bernardino, San Diego

For Central Health Medicare Plan:

H5649-002

Administered by:

Delta Dental of California

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Note: This coverage is for Medicare Supplemental Dental Benefit. Some dental services are available are available through the Medi-Cal Dental. Dental benefits are available in the Medi-Cal Dental Program as a fee-for-service. Authorization rules may apply. For more information, or if you need help finding a dentist who accepts the Medi-Cal Dental Program, contact the Customer Service Line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free.

Medi-Cal Dental Services program representatives are available to assist you from 8:00 am to 5:00 pm., Monday through Friday. You can also visit the website at dental.dhsc.ca.gov/ for more information.

INTRODUCTION

We are pleased to welcome you to the dental plan for **Central Health Medicare Plan**. Your plan is administered by Delta Dental of California ("Delta Dental"). Our goal is to provide you with high 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 dentist, but to see him/her on a regular basis.

Using This Evidence of Coverage

This Dental Benefit Addendum ("Plan"), which includes Attachment A, Deductibles, Maximums and Plan Benefit Levels and, Attachment B, Services, Limitations and Exclusions, 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. Please read the Definitions section, which will explain any words that have special or technical meanings in this Plan.

The benefit explanations contained in this Plan booklet are subject to all provisions of the Contract on file with Central Health Medicare Plan. ("Contract holder") 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.

Notice: *This Plan booklet is a summary of your dental plan and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered Benefits, services or payments.*

Contact Us

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

You can access Delta Dental's automated information line at (855) 370-3867, TTY:711, during regular business hours to obtain information about Member's eligibility and Benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

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

DEFINITIONS

Terms when capitalized in this Plan booklet have defined meanings, given in the section below or throughout the booklet sections.

Appeal -- something you do if you disagree with a decision to deny a request for dental care services or payment for services you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a service you think you should be able to receive.

Benefits -- the amounts that the Plan will pay for covered dental services.

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

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

Contract -- the Agreement between Central Health Medicare Plan and Delta Dental of California for the Provision of Dental Services.

Contract holder -- Central Health Medicare Plan

Cost-sharing -- the amounts which may be charged to Member(s) as the Member's share of the cost for the provision of covered services. Cost sharing consists of coinsurance, copayments, Deductible, and balance billing.

Deductible -- a dollar amount that a Member must pay for certain covered services before the Plan begins paying Benefits.

Delta Dental Participating Medicare Provider (Participating Provider) -- means a person licensed to practice dentistry when and where performed who has entered into a contract with Delta Dental agreeing to participate in this Plan and provide covered services to Members.

Delta Dental Participating Medicare Provider Contracted Fee (Participating Provider Contracted Fee) -- the fee for a Single Procedure covered under the Plan that a Participating Provider has contractually agreed to accept as payment in full for covered services.

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

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

Maximum Plan Allowance -- the reimbursement under the Plan against which Delta Dental calculates the Plan's payment and the Member's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Plan Allowance for services provided by a Participating Provider is the lesser of the Provider's Submitted Fee or the Participating Provider Contracted Fee.

Member -- a person with Medicare who is eligible to get covered services, who has enrolled in the Plan and whose enrollment has been confirmed by CMS.

Non Participating Medicare Provider -- a dentist who has not entered into an agreement with Delta Dental to be a Participating Provider under this Plan.

Participating Provider Contracted Fee -- the fee for a Single Procedure covered under the contract that a Participating Provider has contractually agreed to accept the Maximum Plan Allowance as payment in full for covered services.

Plan -- this dental plan which describes the Benefits, limitations, exclusions, terms and conditions of coverage for Members enrolled in Contract holder's Medicare Advantage Plan.

Plan Benefit Level -- the percentage of the Maximum Plan Allowance that the Plan will pay after the Deductible, if any, has been satisfied as shown in Attachment A.

Plan Year -- the 12 months starting on the Effective Date and each subsequent 12-month period thereafter.

Pre-Treatment Estimate -- an estimation of the allowable Benefits under the Plan for the services proposed.

Prior Authorization – a required pre-approval by Delta Dental before services are rendered.

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

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

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

Submitted Fee -- the amount that the attending dentist bills and enters on a claim for a specific procedure.

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

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

The Plan will pay Benefits for the dental services described in Attachment B. The Plan will pay Benefits only for covered services. The Plan covers several categories of dental services when a Participating Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental 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 during which you are a Member of the Plan.

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 Plan. Even if the dentist 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.

Coinsurance

The Plan will pay a percentage of the Maximum Plan Allowance for covered services, as shown in Attachment A and you are responsible for paying the remaining percentage of Maximum Plan Allowance as well as any additional Cost-sharing. The percentage of the Maximum Plan Allowance you are required to pay is called the coinsurance ("Coinsurance"). The Co-insurance is part of your out-of-pocket cost. You pay these even after a Deductible, if any, has been met. In addition to the Coinsurance, and any remaining Deductible, you may be required to pay any amount in excess of your Maximum Amount and the cost of any non-covered services. This is what we mean by Cost-sharing.

The amount of your Coinsurance will depend on the type of service you receive. Participating Providers are required to collect Coinsurance for covered services. Coinsurance is a method of sharing the costs of providing dental Benefits. If the Participating Provider discounts, waives or rebates any portion of the Coinsurance to you, the Plan will be obligated to provide as Benefits only the applicable percentages of the Maximum Plan Allowance reduced by the amount of the fees or allowances that are discounted, waived or rebated.

Maximum Amount
Most dental programs have a maximum amount. A maximum amount ("Maximum Amount" or "Maximum") is the total dollar amount the Plan will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable, if any, is shown in Attachment A. The Maximum Amount 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 Participating Provider may file a Claim Form with Delta Dental before beginning treatment, showing the services to be provided to you. Delta Dental will estimate the amount of Benefits payable under the Plan for the listed services. By asking your dentist for a Pre-Treatment Estimate from Delta Dental before you agree to receive any prescribed treatment, you will have an estimate up front of what the Plan 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 Plan terminates;
- the date Benefits under the Plan are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Participating Provider's agreement with Delta Dental ends.

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

SELECTING YOUR PROVIDER

You may <u>only</u> receive benefits for covered services provided by a Delta Dental Medicare Advantage Participating Provider. In order to receive Benefits under this Plan, the dental care you receive must be covered services and they must be provided by a Participating Provider. The Plan does not pay Benefits for dental care that are not covered services and to be entitled to Benefits for covered services they must be provided by a Participating Provider, unless the services are provided in an emergency. We highly recommend you verify that the dentist is a Participating Provider in this dental Plan before each appointment. Review the section titled "How Claims Are Paid" for an explanation of payment procedures to understand the method of payments applicable to your Participating Provider selection.

Locating a Delta Dental Medicare Advantage Participating Provider
There are two ways in which you can locate a Medicare Advantage Participating Provider near you:

- You may access information through our website at deltadentalins.com/centralhealth. This website includes a Provider search function allowing you to locate Participating Providers by location and specialty; or

- You may also call Delta Dental's Customer Service Center toll-free at (855) 370-3867, TTY: 711, and a representative will assist you. Delta Dental can provide you with information regarding a Delta Dental Participating Provider's specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Participating Provider
Selecting a Participating Provider allows the Member to obtain Benefits for covered services performed for you. Payment to a Participating Provider is calculated based on the Maximum Plan Allowance. Participating Providers agree to accept Delta Dental's Maximum Plan Allowance as payment in full for covered services which means you will only be responsible for any applicable Cost Sharing for the covered service.

The portion of the Maximum Plan Allowance payable by the Plan is limited to the applicable Plan Benefit Level shown in Attachment A. The Plan's payment is sent directly to the Participating Provider who submitted the claim. Delta Dental will advise you of any charges not payable by the Plan for which you are responsible. These Cost Sharing charges are generally your share of the Maximum Plan Allowance (Coinsurance), as well as any Deductibles, charges where the Maximum Amount has been exceeded, and/or charges for non-covered services.

Payment for Services – Non Participating Provider
Except in the case of an emergency where a Participating Provider is not available to provide you with care you need, the Plan does not pay any Benefits for dental services (regardless of whether they are covered services) if the services are provided by a Non Participating Provider. You will be solely responsible for any dental care provided by a Non Participating Provider.

Delta Dental contracts with licensed dentists who participate in other dental plans offered by Delta Dental. Not all of these dentists agree or contract with Delta Dental to be a Participating Provider in this Plan. We therefore highly recommend that you verify that the dentist you select is a Participating Provider in this dental Plan before each appointment. The dentist may be under contract for another Delta Dental benefits plan but not necessarily this Plan for Central Health Medicare Plan's Medicare Advantage beneficiaries.

How to Submit a Claim
Delta Dental does not require special claim forms. However, most dental offices have Claim Forms available. Participating Providers will fill out and submit your claims paperwork for you. Some Non-Participating Providers may also provide this service upon your request. If you wish to submit your own claim directly to Delta Dental. 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 95899-7330

CLAIMS APPEAL

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Participating Providers to the courtesy extended you by Delta Dental's telephone representatives. If you have any question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Participating Provider, you have the right to file a grievance or appeal with Central Health Medicare Plan at 866-314-2427.

GENERAL PROVISIONS

Clinical Examination
Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which dental 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 the Plan's expense, in or near your community or residence. Delta Dental will in every case hold such information and records confidential.

Notice of Claim Form
Delta Dental will give you or your Participating Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Participating 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 Delta Dental within 15 days after requested by you or your Participating 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 Delta Dental, 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 Participating Provider may download a Claim Form from Delta Dental's website.

Written Notice of Claim/Proof of Loss
Delta Dental 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 Delta Dental within 12 months of the termination of the Plan.

Time of Payment
Claims payable under the Plan for any loss other than loss for which the Plan provides any periodic payment will be processed immediately after written proof of loss is received. Delta Dental will notify you and your Participating Provider of any additional information needed to process the claim.

To Whom Benefits Are Paid
It is not required that the service be provided by a specific Participating Provider, only that the treating dentist be a Participating Provider. Payment for covered services will be made directly to the provided by a Participating Provider. Any other payments provided by the Plan will be made to you. All Benefits not paid to the Participating Provider will be payable to you, or to your estate, or to an alternate recipient as directed by court order, except that if the person is not competent to give a valid release, Benefits may be payable to his or her spouse or guardian or other legally appointed representative.

Legal Actions
No action at law or in equity will be brought to recover under the Plan prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Plan, 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 Plan.

DEDUCTIBLES, MAXIMUMS & BENEFITS DESCRIPTION

Contract holder: **Central Health Medicare Plan**

Group Number: **23043** **Effective Date:** January 1, 2025

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT HOLDER SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS.

Schedule of Benefits	
Annual Deductible Per Member	**No Deductible**

Maximum		
	Delta Dental Participating Medicare Providers	Non-Participating Providers
Annual Maximum	$1,000 per Member	Not Covered

Dental Service Category		In-Network You Pay	Out-of-Network You Pay
Preventive Care: No Maximum Allowance			
Oral Exam:	2 every Calendar Year	**0%**	**100%**
Detail:	D0120, D0140, D0150, or D0180; D0150 and D0180 allowed once per provider per lifetime		
Prophylaxis - Cleaning	2 every Calendar Year	**0%**	**100%**
Detail:	D1110		
Fluoride Treatment	2 every Calendar Year	**0%**	**100%**
Detail:	D1206, D1208		
Bitewing X-ray:	4 every Calendar Year	**0%**	**100%**
Detail:	D0272, D0274, D0373		
Periapicals:	6 every Calendar Year	**0%**	**100%**
Detail:	D0220, D0230		
Diagnostic: No Maximum Allowance			
Panoramic Radiographic x-ray:	1 every 5 calendar years	**0%**	**100%**
Detail:	D0330 or D0372; not covered with D0272, D0274 or D0373 within the same Calendar Year.		
Intraoral Tomosynthesis – Periapical radiographic x-ray:	1 every Calendar Year	**0%**	**100%**
Detail:	D0374		
Periodontics			
Scaling:	4 quadrants every 2 Calendar Years	**0%**	**100%**
Detail:	any combination of either D4341 or D4342		
Debridement:	Covered as referenced:	**0%**	**100%**
Detail:	1 every Calendar Year - D4355 2 every Calendar Year - D4910		
Restorative Services			
Fillings:	6 fillings every Calendar Year	**0%**	**100%**
Detail:	D2140- D2161; D2330-D2335; D2391-D2394		
Crowns:	2 crowns every Calendar Year; one per tooth every 5 Calendar Years	**0%**	**100%**
Detail:	D2510-D2530; D2542-D2544; D2620, D2630; D2642-D2644; D2650-D2652; D2662-D2664; D2710-D2722; D2740; D2751, D2752; D2781-D2783; D2790-D2794; D2799		

Crown Restoration - Pin Retention:	2 every Calendar Year	**0%**	**100%**
Detail:	D2951 D2952; D2953; D2954; D2980		
Crown Restoration/Repair	2 every Calendar Year	**0%**	**100%**
Detail:	1 every Calendar Year - D2951; D2980 2 every Calendar Year - D2952, D2954 2 every Calendar Year - D2953		
Crown Repair	1 per tooth every 5 Calendar Years	**0%**	**100%**
Detail:	D2980		
Extractions*			
Simple Extractions:	8 every Calendar Year	**0%**	**100%**
Detail:	D7140		
Surgical Extraction:	3 every Calendar Year	**0%**	**100%**
Detail:	D7210-D7241		
Incision and Drainage:	1 per tooth per lifetime	**0%**	**100%**
Detail:	D7510, D7511 or D7520, D7521		
Endodontics*			
Endodontics/Root Canals	1 per tooth every Calendar Year	**0%**	**100%**
Detail:	D3220; D3310-D3330; D3410, D3421, D3425, D3426		
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services*			
Dentures:	1 set of dentures (either full, partial or immediate) every 3 Calendar Years; up to the Plan Annual Maximum Coverage Amount	**0%**	**100%**
Detail:	D5110-D5140; D5211-D5214; D5221-D5228		
Denture Repairs:	4 every Calendar Year	**0%**	**100%**
Detail:	D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5670, D5671, D5710, D5711, D5720, D5721, D5725, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765		

Palliative Emergency Treatment:	4 every Calendar Year	**0%**	**100%**
Detail:	D9110		
Deep Sedation (Anesthesia):	Covered with Oral Surgery	**0%**	**100%**
Detail:	D9222, D9223		
Intravenous (Anesthesia):	Covered with Oral Surgery	**0%**	**100%**
Detail:	D9239, D9243		

**** Some services within this category may require prior authorization.***

EXCLUSIONS ON BENEFITS

The Plan does 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. 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).

(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 Member 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 dentist 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) Interim implants and endodontic endosseous implant.

(12) Indirectly fabricated resin-based Inlays/Onlays.

(13) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

(14) Treatment by someone other than a dentist or a person who by law may work under a dentist's direct supervision.

(15) 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.

(16) 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.

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

(18) Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Plan, will be the responsibility of the Member and not a covered Benefit.

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

(20) 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.

(21) Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section.

(22) 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.

(23) 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.

(24) Services not included in the Schedule of Benefits.

(25) Missed and/or cancelled appointments.