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## **DENTAL BENEFITS**

**VITALITY HEALTH PLAN OF CALIFORNIA, INC.**

**Vitality Choice (HMO)**

Administered by:



Delta Dental of California

**Evidence of Coverage for Delta Dental of California  
Vitality Choice (HMO) Dental Benefits**

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## **INTRODUCTION**

We are pleased to welcome you to the dental plan for Vitality Health Plan of California, Inc. 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.

This plan is available in the following counties: Santa Clara and San Joaquin counties.

### **Using This Evidence of Coverage**

This Dental Benefit Addendum (“Plan”), which includes Attachment A, Schedule of Copayments 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 Vitality Health Plan of California, Inc. (“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 [www.VitalityHP.net](http://www.VitalityHP.net) or call Delta Dental’s Customer Service Center at (866) 241-6833 (TTY 711). 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 (866) 241-6833 (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  
1130 Sanctuary Parkway  
Alpharetta, GA 30009

## **DEFINITIONS**

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

**Appeal** is 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 Vitality Health Plan of California for an appeal if our Plan doesn't pay for a service you think you should be able to receive.

**Benefits** - the dental services under this Plan to which you are entitled to receive.

**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 Vitality Health Plan of California, Inc. and Delta Dental of California for the Provision of Dental Services.

**Contract holder** – Vitality Health Plan of California, Inc.

**Cost-sharing** – the amounts which may be charged to a Member as the Member's share of the cost for the provision of covered services. Cost sharing under this Plan consists of copayments listed in Attachment A.

**Delta Dental Participating 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 in general dentistry to Members.

**Emergency Service** - dental care furnished to a Member 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 Member to result in either: (i) placing the Member's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

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

**Grievance** – A grievance is any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of Vitality Health Plan of California, or its providers, such as Delta Dental, regardless of whether remedial action is requested.

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

**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 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.

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

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

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

**Specialist Services** - mean services performed by a licensed dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

**Treatment in Progress** - means any single dental procedure, as defined by the Procedure Code that has been started while the Member was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Member continues to be eligible for Benefits under the 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.

### **How to use this Plan - Choice of Participating Provider**

To receive Benefits under this Plan, you must select a Participating Provider from the directory of Participating Providers. If you fail to select a Participating Provider or the Participating Provider selected by you becomes unavailable, we will request you select another Participating Provider or we will assign you to a Participating Provider. You may change your assigned Participating Provider by directing a request to the Customer Service department at (866) 241-6833 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711). In

order to ensure that your Participating Provider is notified and our eligibility lists are correct, changes in Participating Providers must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a membership packet that tells you the effective date of your Plan and the address and telephone number of your Participating Provider. After the effective date in your membership packet, you may obtain dental services under the Plan. To make an appointment simply call your Participating Provider's facility and identify yourself as a Member through Vitality Health Plan of California, Inc. Inquiries regarding availability of appointments and accessibility of Participating Providers should be directed to the Customer Service department at (866) 241-6833 (TTY users 711).

**EACH MEMBER MUST GO TO HIS OR HER ASSIGNED PARTICIPATING PROVIDER TO OBTAIN COVERED SERVICES, EXCEPT EMERGENCY SERVICES OR SERVICES PROVIDED BY A SPECIALIST, WHICH MUST BE PREAUTHORIZED IN WRITING BY DELTA DENTAL. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PLAN.**

If your assigned Participating Provider's agreement with Delta Dental terminates, that Participating Provider will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

### **Continuity of Care**

#### Existing Members:

You may have the right to have completion of care with your terminated Participating Provider for certain specified dental conditions. Please call Customer Service at (866) 241-6833 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Participating Provider. We are not required to continue your care with that Participating Provider if you are not eligible for coverage under the Plan or if we cannot reach agreement with your terminated Participating Provider on the terms regarding your care.

#### New Members:

You may have the right to the qualified benefit of completion of care with a Non Participating Provider for certain specified dental conditions. Please call the Customer Service department at (866) 241-6833 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Non Participating Provider. We are not required to continue your care with that dentist if you are not eligible under the Plan or if we cannot reach agreement with your dentist on the terms regarding your care.

### **Facility Accessibility**

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information

regarding facility accessibility, contact Delta Dental's Customer Service department at (866) 241-6833 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711).

### **Benefits, Limitations and Exclusions**

This Plan provides the Benefits described in Attachment A, *Description of Benefits and Copayments* subject to the limitations and exclusions described in Attachment B. The services are performed as deemed appropriate by your attending Participating Provider. A Participating Provider may provide services either personally or through associated dentists, technicians or hygienists who may lawfully perform the services.

### **Copayments and Other Charges**

You are required to pay any Copayments listed in the Attachment A, *Description of Benefits and Copayments* directly to the Participating Provider or Specialist who provides treatment. Charges for broken appointments (unless notice is received by the dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

### **Emergency Services**

If Emergency Services are needed, you should contact your Participating Provider whenever possible. If you are a new Member needing Emergency Services, but do not have an assigned Participating Provider yet, contact Delta Dental's Customer Service department at (866) 241-6833 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) for help in locating a Participating Provider. Benefits for Emergency Services by a Non Participating Provider are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

- 1) have made a Reasonable attempt to contact the Participating Provider and the Participating Provider is unavailable or you cannot be seen within 24 hours of making contact; or
- 2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or
- 3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Participating Provider to receive Emergency Services.

Benefits for Emergency Services not provided by the Participating Provider are limited to a maximum of \$100.00 per emergency less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a dentist other than your Participating Provider.

### **Specialist Services**

Specialist Services must be referred by the assigned Participating Provider and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

### **Second Opinion**

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Participating Provider. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at (866) 241-6833 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) or write to Delta Dental.

Second opinions will be provided at another Participating Provider's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by a Non Participating Provider if an appropriately qualified Participating Provider is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file an Appeal with Bright Health. Please refer to the section of this booklet titled "Grievance and Appeals Process" below for an explanation of how to file an Appeal.

### **Claims for Reimbursement**

Claims for Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P. O. Box 1810, Alpharetta, GA 30023.

### **Provider Compensation**

A Participating Provider is compensated by Delta Dental through monthly capitation (an amount based on the number of Members assigned to the Participating Provider), and by Members through required Cost Sharing for treatment received. A Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Member. In no event does Delta Dental pay a Participating Provider or a Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event we fail to pay a Participating Provider, you will not be liable to that Participating Provider for any sums owed by us. The Participating Provider's contract with Delta Dental contains a provision prohibiting the Participating Provider from charging a Member for any sums owed by Delta Dental. Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from a Non Participating Provider or Specialist, and we fail to pay that dentist you may be liable to that dentist for the cost of services.

**You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number listed in this booklet.**

### **Processing Policies**



The dental care guidelines for the Plan explain to Participating Providers what services are covered under the dental Contract. Participating Providers will use their professional judgment to determine which services are appropriate for the Member. Services performed by the Participating Provider that fall under the scope of Benefits of the dental Plan are provided subject to any Copayments. If a Participating Provider believes that a Member should obtain treatment from a Specialist, the Participating Provider contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Specialist. A Member may contact Delta Dental's Customer Service department at (866) 241-6833 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) for information regarding the dental care guidelines for the Plan.

### **Coordination of Benefits**

This Plan provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits Plan if the other policy or Plan covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Plan by Specialists or Non Participating Providers are coordinated with such other group dental insurance policy or any group dental benefits Plan. The determination of which policy or Plan is primary shall be governed by the rules stated in the Contract.

If this plan is secondary, it will pay the lesser of:

- the amount that it would have paid in the absence of any other dental benefit coverage,
- or
- the enrollee's total out-of-pocket cost payable under the primary dental benefit plan.

A Member must provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Member that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Plan. Delta Dental will have the right to recover from a dentist, Member, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

### **Grievance and Appeals Process**

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 our 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 Vitality Health Plan of California, Inc. See your Vitality Health Plan of California, Inc. Evidence of Coverage Booklet for information on the grievance process or contact Vitality Health Plan of California at 1-866-

333-3530 from 8 a.m. to 8 p.m. seven days a week from October 1 through March 31, and 8 a.m. to 8 p.m. Monday to Friday from April 1 through September 30.

### **Renewal and Termination of Benefits**

This Plan renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and Vitality Health Plan of California, Inc. does not accept the change. All Benefits terminate for any Member as of the date that this Plan is terminated, such person ceases to be eligible under the terms of this Plan, or such person's enrollment is cancelled under the terms of this Plan. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of Single Procedures commenced while this Plan was in effect.

### **Cancellation of Enrollment**

To be eligible for Benefits under this Plan, you must be enrolled under one of the various Medicare Advantage health plans or products offered by Vitality Health Plan of California. If you lose your eligibility or you terminate your enrollment under your Vitality Health Plan of California, Inc. you are not eligible to receive Benefits under this Plan. See your Vitality Health Plan of California, Inc. Evidence of Coverage Booklet for enrollment terms and conditions.

## SCHEDULE A

### Description of Benefits and Copayments

#### CAC19

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

**Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DHMO Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2018 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.**

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient .....	No Cost
D0140	Limited oral evaluation - problem focused.....	No Cost
D0150	Comprehensive oral evaluation - new or established patient.....	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report.....	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).....	No Cost
D0171	Re-evaluation - post-operative office visit.....	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient.....	No Cost
D0190	Screening of a patient.....	No Cost
D0191	Assessment of a patient.....	No Cost
D0210	Intraoral - complete series of radiographic images - <i>limited to 1 series every 24 months</i> .....	No Cost
D0220	Intraoral - periapical first radiographic image .....	No Cost
D0230	Intraoral - periapical each additional radiographic image .....	No Cost
D0240	Intraoral - occlusal radiographic image .....	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector .....	No Cost
D0251	Extraoral posterior dental radiographic image.....	No Cost
D0270	Bitewing - single radiographic image .....	No Cost
D0272	Bitewings - two radiographic images .....	No Cost
D0273	Bitewings three radiographic images.....	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i> .....	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images .....	No Cost
D0330	Panoramic radiographic image .....	No Cost
D0460	Pulp vitality tests.....	No Cost
D0470	Diagnostic casts .....	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk	

	- 1 every 3 years .....	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk	
	- 1 every 3 years .....	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk	
	- 1 every 3 years .....	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i> .....	No Cost

D1000-D1999    II. PREVENTIVE

D1110	Prophylaxis cleaning - adult - 1 D1110 or D4346 per 6-month period .....	No Cost
D1208	Topical application of fluoride - excluding varnish - 1 per 6-month period .....	No Cost

D2000-D2999    III. RESTORATIVE

- *Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*

- *When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$100.00 per crown, beyond the 6th unit.*

- *Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.*

*\* The provider may charge an additional fee up to \$250.00 for noble or high noble metal.*

D2140	Amalgam - one surface, primary or permanent .....	\$24.00
D2150	Amalgam - two surfaces, primary or permanent .....	\$26.00
D2160	Amalgam - three surfaces, primary or permanent .....	\$28.00
D2161	Amalgam - four or more surfaces, primary or permanent .....	\$30.00
D2330	Resin-based composite - one surface, anterior .....	\$25.00
D2331	Resin-based composite - two surfaces, anterior .....	\$31.00
D2332	Resin-based composite - three surfaces, anterior .....	\$35.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) .....	\$47.00
D2391	Resin-based composite - one surface, posterior .....	\$75.00
D2392	Resin-based composite - two surfaces, posterior .....	\$85.00
D2393	Resin-based composite - three surfaces, posterior .....	\$95.00
D2394	Resin-based composite - four or more surfaces, posterior .....	\$105.00
D2510	Inlay - metallic - one surface* .....	\$300.00
D2520	Inlay - metallic - two surfaces* .....	\$300.00
D2530	Inlay - metallic - three or more surfaces* .....	\$300.00
D2542	Onlay - metallic - two surfaces* .....	\$300.00
D2543	Onlay - metallic - three surfaces* .....	\$300.00
D2544	Onlay - metallic - four or more surfaces* .....	\$300.00
D2610	Inlay - porcelain/ceramic - one surface .....	\$300.00
D2620	Inlay - porcelain/ceramic - two surfaces .....	\$300.00
D2630	Inlay - porcelain/ceramic - three or more surfaces .....	\$300.00
D2642	Onlay - porcelain/ceramic - two surfaces .....	\$300.00
D2643	Onlay - porcelain/ceramic - three surfaces .....	\$300.00
D2644	Onlay - porcelain/ceramic - four or more surfaces .....	\$300.00
D2650	Inlay - resin-based composite - one surface .....	\$175.00
D2651	Inlay - resin-based composite - two surfaces .....	\$300.00
D2652	Inlay - resin-based composite - three or more surfaces .....	\$300.00
D2662	Onlay - resin-based composite - two surfaces .....	\$300.00

D2663	Onlay - resin-based composite - three surfaces .....	\$300.00
D2664	Onlay - resin-based composite - four or more surfaces .....	\$300.00
D2710	Crown - resin-based composite (indirect).....	\$195.00
D2712	Crown - ¾ resin-based composite (indirect).....	\$195.00
D2720	Crown - resin with high noble metal*.....	\$300.00
D2721	Crown - resin with predominantly base metal .....	\$300.00
D2722	Crown - resin with noble metal* .....	\$300.00
D2740	Crown - porcelain/ceramic.....	\$300.00
D2750	Crown - porcelain fused to high noble metal*.....	\$300.00
D2751	Crown - porcelain fused to predominantly base metal .....	\$300.00
D2752	Crown - porcelain fused to noble metal* .....	\$300.00
D2780	Crown - ¾ cast high noble metal* .....	\$300.00
D2781	Crown - ¾ cast predominantly base metal.....	\$300.00
D2782	Crown - ¾ cast noble metal* .....	\$300.00
D2790	Crown - full cast high noble metal*.....	\$300.00
D2791	Crown - full cast predominantly base metal .....	\$300.00
D2792	Crown - full cast noble metal* .....	\$300.00
D2794	Crown - titanium* .....	\$300.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.....	\$20.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core .....	\$20.00
D2920	Re-cement or re-bond crown .....	\$25.00
D2921	Reattachment of tooth fragment, incisal edge or cusp ( <i>anterior</i> ) .....	\$47.00
D2931	Prefabricated stainless steel crown - permanent tooth.....	\$75.00
D2940	Protective restoration .....	\$16.00
D2941	Interim therapeutic restoration - primary dentition.....	\$16.00
D2949	Restorative foundation for an indirect restoration .....	\$50.00
D2950	Core buildup, including any pins when required .....	\$50.00
D2951	Pin retention - per tooth, in addition to restoration.....	\$40.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> .....	\$85.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> .....	\$85.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post</i> ; <i>includes canal preparation</i> .....	\$75.00
D2957	Each additional prefabricated post - same tooth - <i>base metal post</i> ; <i>includes canal preparation</i> .....	\$75.00
D2980	Crown repair necessitated by restorative material failure.....	\$45.00
D2981	Inlay repair necessitated by restorative material failure .....	\$45.00
D2982	Onlay repair necessitated by restorative material failure.....	\$45.00
D2983	Veneer repair necessitated by restorative material failure.....	\$45.00

D3000-D3999    IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration) .....	\$15.00
D3120	Pulp cap - indirect (excluding final restoration) .....	\$15.00
D3221	Pulpal debridement, primary and permanent teeth .....	\$55.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) .....	\$225.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration) .....	\$275.00
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration).....	\$375.00
D3346	Retreatment of previous root canal therapy - anterior .....	\$250.00
D3347	Retreatment of previous root canal therapy - premolar .....	\$350.00
D3348	Retreatment of previous root canal therapy - molar .....	\$475.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of	

	perforations, root resorption, etc.) .....	\$90.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) .....	\$75.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) .....	\$225.00
D3410	Apicoectomy - anterior .....	\$150.00
D3421	Apicoectomy - premolar (first root).....	\$175.00
D3425	Apicoectomy - molar (first root).....	\$200.00
D3426	Apicoectomy (each additional root).....	\$150.00
D3427	Periradicular surgery without apicoectomy .....	\$150.00
D3430	Retrograde filling - per root .....	\$50.00
D3450	Root amputation - per root.....	\$85.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant .....	\$250.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$60.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth .....	\$60.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant .....	\$225.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$225.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant .....	\$375.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.....	\$375.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	\$85.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	\$85.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110 or D4346 per 6 month period</i> .....	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i> .....	\$85.00
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i> .....	\$65.00
D4921	Gingival irrigation - per quadrant .....	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary .....	\$400.00
D5120	Complete denture - mandibular .....	\$400.00

D5130	Immediate denture - maxillary.....	\$500.00
D5140	Immediate denture - mandibular.....	\$500.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).....	\$375.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).....	\$375.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).....	\$475.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).....	\$475.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).....	\$375.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).....	\$375.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).....	\$475.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).....	\$475.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).....	\$350.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).....	\$350.00
D5410	Adjust complete denture - maxillary.....	\$15.00
D5411	Adjust complete denture - mandibular.....	\$15.00
D5421	Adjust partial denture - maxillary.....	\$15.00
D5422	Adjust partial denture - mandibular.....	\$15.00
D5511	Repair broken complete denture base, mandibular.....	\$35.00
D5512	Repair broken complete denture base, maxillary.....	\$35.00
D5520	Replace missing or broken teeth - complete denture (each tooth).....	\$35.00
D5611	Repair resin partial denture base, mandibular.....	\$35.00
D5612	Repair resin partial denture base, maxillary.....	\$35.00
D5621	Repair cast partial framework, mandibular.....	\$35.00
D5622	Repair cast partial framework, maxillary.....	\$35.00
D5630	Repair or replace broken clasp - per tooth.....	\$35.00
D5640	Replace broken teeth - per tooth.....	\$35.00
D5650	Add tooth to existing partial denture.....	\$20.00
D5660	Add clasp to existing partial denture - per tooth.....	\$20.00
D5710	Rebase complete maxillary denture.....	\$130.00
D5711	Rebase complete mandibular denture.....	\$130.00
D5720	Rebase maxillary partial denture.....	\$130.00
D5721	Rebase mandibular partial denture.....	\$130.00
D5730	Reline complete maxillary denture (chairside).....	\$85.00
D5731	Reline complete mandibular denture (chairside).....	\$85.00
D5740	Reline maxillary partial denture (chairside).....	\$85.00
D5741	Reline mandibular partial denture (chairside).....	\$85.00
D5750	Reline complete maxillary denture (laboratory).....	\$145.00
D5751	Reline complete mandibular denture (laboratory).....	\$145.00
D5760	Reline maxillary partial denture (laboratory).....	\$145.00
D5761	Reline mandibular partial denture (laboratory).....	\$145.00
D5820	Interim partial denture (maxillary) - <i>limited to 1 in any 12 consecutive months</i> .....	\$150.00
D5821	Interim partial denture (mandibular) - <i>limited to 1 in any 12 consecutive months</i> .....	\$150.00
D5850	Tissue conditioning, maxillary.....	\$35.00

D5851 Tissue conditioning, mandibular.....\$35.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

*- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$100.00 per unit, beyond the 6th unit.*

*- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*

D6210	Pontic - cast high noble metal.....	\$495.00
D6211	Pontic - cast predominantly base metal .....	\$350.00
D6212	Pontic - cast noble metal .....	\$365.00
D6214	Pontic - titanium.....	\$495.00
D6240	Pontic - porcelain fused to high noble metal .....	\$570.00
D6241	Pontic - porcelain fused to predominantly base metal .....	\$425.00
D6242	Pontic - porcelain fused to noble metal.....	\$440.00
D6245	Pontic - porcelain/ceramic .....	\$485.00
D6250	Pontic - resin with high noble metal .....	\$570.00
D6251	Pontic - resin with predominantly base metal.....	\$425.00
D6252	Pontic - resin with noble metal .....	\$440.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces .....	\$330.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces .....	\$355.00
D6602	Retainer inlay - cast high noble metal, two surfaces .....	\$360.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces .....	\$395.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces .....	\$260.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces .....	\$295.00
D6606	Retainer inlay - cast noble metal, two surfaces.....	\$260.00
D6607	Retainer inlay - cast noble metal, three or more surfaces .....	\$295.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces .....	\$375.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces .....	\$410.00
D6610	Retainer onlay - cast high noble metal, two surfaces.....	\$375.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces .....	\$410.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces .....	\$275.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces.....	\$310.00
D6614	Retainer onlay - cast noble metal, two surfaces.....	\$275.00
D6615	Retainer onlay - cast noble metal, three or more surfaces .....	\$310.00
D6720	Retainer crown - resin with high noble metal.....	\$570.00
D6721	Retainer crown - resin with predominantly base metal .....	\$425.00
D6722	Retainer crown - resin with noble metal .....	\$440.00
D6740	Retainer crown - porcelain/ceramic .....	\$480.00
D6750	Retainer crown - porcelain fused to high noble metal .....	\$570.00
D6751	Retainer crown - porcelain fused to predominantly base metal.....	\$425.00
D6752	Retainer crown - porcelain fused to noble metal .....	\$440.00
D6780	Retainer crown - $\frac{3}{4}$ cast high noble metal.....	\$495.00
D6781	Retainer crown - $\frac{3}{4}$ cast predominantly base metal .....	\$350.00
D6782	Retainer crown - $\frac{3}{4}$ cast noble metal.....	\$365.00



D6790	Retainer crown - full cast high noble metal .....	\$495.00
D6791	Retainer crown - full cast predominantly base metal.....	\$350.00
D6792	Retainer crown - full cast noble metal .....	\$365.00
D6794	Retainer crown - titanium .....	\$495.00
D6930	Re-cement or re-bond fixed partial denture .....	\$45.00
D6940	Stress breaker .....	\$155.00
D6980	Fixed partial denture repair necessitated by restorative material failure .....	\$85.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) .....	\$20.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated .....	\$75.00
D7220	Removal of impacted tooth - soft tissue .....	\$75.00
D7230	Removal of impacted tooth - partially bony .....	\$100.00
D7240	Removal of impacted tooth - completely bony.....	\$125.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications .....	\$150.00
D7250	Removal of residual tooth roots (cutting procedure) .....	\$65.00
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i> .....	\$45.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	\$125.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.....	\$125.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant .....	\$145.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	\$145.00
D7471	Removal of lateral exostosis (maxilla or mandible) .....	\$125.00
D7510	Incision and drainage of abscess - intraoral soft tissue.....	\$45.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure .....	No Cost
D7970	Excision of hyperplastic tissue - per arch .....	\$125.00
D7971	Excision of pericoronal gingiva.....	\$125.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$125.00, may apply.

- The retention copayment includes adjustments and/or office visits up to 24 months.

- Pre-treatment and Post-treatment records and study models are excluded.

D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$1,350.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$1,800.00
D8660	Pre-orthodontic treatment examination to monitor growth and development .....	\$25.00

D8670	Periodic orthodontic treatment visit.....	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers).....	No Cost
D8681	Removable orthodontic retainer adjustment.....	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i> .....	\$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure .....	\$35.00
D9211	Regional block anesthesia.....	No Cost
D9212	Trigeminal division block anesthesia.....	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures .....	No Cost
D9219	Evaluation for deep sedation or general anesthesia .....	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician .....	\$65.00
D9311	Consultation with medical health care professional .....	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed .....	\$8.00
D9440	Office visit - after regularly scheduled hours .....	\$50.00
D9450	Case presentation, detailed and extensive treatment planning.....	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary.....	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular.....	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary .....	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular .....	No Cost
D9951	Occlusal adjustment, limited.....	\$55.00
D9952	Occlusal adjustment, complete .....	\$105.00
D9986	Missed appointment - <i>without 24 hour notice</i> .....	\$15.00
D9987	Canceled appointment - <i>without 24 hour notice</i> .....	\$15.00
D9991	Dental case management - addressing appointment compliance barriers .....	No Cost
D9992	Dental case management - care coordination .....	No Cost
D9995	Teledentistry - synchronous; real-time encounter.....	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review .....	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by the Plan. The Enrollee pays the Copayment specified for such services.

## SCHEDULE B

### Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

### Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
  - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
  - b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
4. Lost or stolen appliances including, but not limited to, full or partial dentures, crowns and fixed partial dentures (bridges).
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations for non-covered benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Benefit booklet.

10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Prescription drugs.
12. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DHMO Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics.
13. Changes in orthodontic treatment necessitated by accident of any kind.
14. Myofunctional and parafunctional appliances and/or therapies.
15. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
16. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.
17. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture.
18. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on *Schedule A, Description of Benefits and Copayments*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.
19. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

Vitality Health Plan of California is an HMO with a Medicare contract. Enrollment in Vitality Health Plan of California depends on contract renewal.

This information is not a complete description of benefits. Call 1-866-333-3530 (TTY 711) for more information 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and 8 a.m. to 8 p.m. Monday to Friday from April 1 through September 30. Other providers are available in our network.

## **Proficiency of Language Assistance Services are Available**

**Hours: 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and Monday to Friday from April 1 through September 30**

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-333-3530 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-333-3530 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-333-3530 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-333-3530 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-333-3530 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-333-3530 (TTY: 711) 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ձանգահարեք 1-866-333-3530 (TTY (հեռատիպ) 711):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-333-3530 (TTY: 711) تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-333-3530 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-333-3530 (TTY:711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-333-3530 (رقم هاتف الصم والبكم: 711).

ਪਿਆਨੀਦਿਓ: ਜੀਤੁਸੀਂਪੰਜਾਬੀ ਬੋਲਦੀਹੋ, ਤੀਭਾਸ਼ੀਵਿੱਚੀਸਹਾਇਤੀਸੇਵਾਤੁਹਾਡੀਲਈਮੁਫਤੀਉਪਲਬਧੀਹੈ।1-866-333-3530 (TTY: 711) 'ਤੀਕਾਲੀਕਰੋ।

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-866-333-3530 (TTY: 711)។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-333-3530 (TTY: 711).

ध्यानितें: यदिआप हिंदीबोलतीहैतो आपके लिए मुफतीमौभाषा सहायतीसेवाएँ उपलब्धीहैं।1-866-333-3530 (TTY: 711) परीकालीकरें।

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-333-3530 (TTY: 711).

## **Discrimination is Against the Law**

Vitality Health Plan of California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location. Vitality Health Plan of California does not exclude people or treat them differently because of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location.

Vitality Health Plan of California:

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

If you need these services, contact Vitality Member Service Department at 1-866-333-3530 (TTY: 711) to help you. Hours are 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and Monday to Friday from April 1 through September 30. You can also ask for a Civil Rights Coordinator who works for Vitality Health Plan of California.

If you believe that Vitality Health Plan of California has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Vitality Health Plan of California  
Member Services Department (Complaints)  
18000 Studebaker Road, Suite 960 Cerritos, CA 90703  
1-866-333-3530 TTY: 711 FAX: 1-866-207-6539

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Vitality Civil Rights Coordinator is available to help you.

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>.

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Vitality Health Plan of California cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Vitality Health Plan of California 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。