

Combined Evidence of Coverage and Disclosure Form



THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF YOUR BENEFITS.

DELTA DENTAL PPO PLAN FOR GROUP NUMBER: 00444

Dental Services*	Delta Dental's Applicable Percentage for PPO Dentists	Delta Dental's Applicable Percentage for Premier Dentists	Delta Dental's Applicable Percentage for Non-Contracting Dentists**	Waiting Periods	Calendar Year Deductible and Maximum
Diagnostic & Preventive Benefits	100%	100%	100%	None	\$25 for each Enrollee up to a limit of \$50 per family The deductible does not apply to Diagnostic, Preventive and Orthodontic Benefits.
Basic Benefits	80%	80%	80%	None	
Crowns, Inlays, Onlays & Cast Restorations	50%	50%	50%	None	
Prosthodontic Benefits	50%	50%	50%	12 Months	The annual maximum for each Enrollee is \$2,000.
Emergency & Dental Accident Benefits	NA	NA	NA	None	
Orthodontics (for dependent children only)	50%	50%	50%	12 Months	The lifetime maximum for each Enrollee is \$2,000.

You are free to choose any licensed dentist to provide your dental services. It may be to your financial advantage to choose a Delta Dental PPO Dentist whose fees are generally lower than a Delta Dental Premier or a non-contracting dentist. You are responsible for your percentage cost share to a PPO or Premier Dentist. When using a non-contracting dentist you are responsible for the difference between the amount paid by Delta Dental and the amount charged by a non-contracting dentist.

* Please refer to the Benefits, Limitations & Exclusion sections of your Evidence of Coverage

** If you go to a non-contracting dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered.

USING THIS BOOKLET

This booklet has been written with you in mind. It is designed to help you make the most of your Delta Dental plan. This combined Evidence of Coverage/Disclosure form discloses the terms and conditions of your coverage.

The Combined Evidence of Coverage/Disclosure form should be read completely and carefully and individuals with special health care needs should read carefully those sections that apply to them (see CHOICE OF DENTISTS AND PROVIDERS section). You have a right to review it prior to your enrollment.

Please read the "DEFINITIONS" section. It will explain to you any words that have special or technical meanings under your group Contract. A copy of the Contract will be furnished upon request.

Please read this summary of your dental Benefits carefully. Keep in mind that YOU means the ENROLLEES whom Delta Dental covers. WE, US and OUR always refers to Delta Dental of California (Delta Dental).

If you have any questions about your coverage that are not answered here, please check with your personnel office, or with Delta Dental.

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

For claims, eligibility and benefits inquiries, or additional information, call Delta Dental's Customer Service Department toll-free at 1-888-335-8227 or contact us on the Internet at:

deltadentalins.com

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the dental plan. The dental Contract must be consulted to determine the exact terms and conditions of coverage.

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DEFINITIONS

Certain words that you will see in this booklet have specific meanings. These definitions should make your dental plan easier to understand.

ACWA/JPIA – Association of California Water Agencies/Joint Powers Insurance Authority of the dental health care plan.

Benefits - those dental services available under the Contract with ACWA/JPIA and which are described in this booklet.

Contract - the written agreement between ACWA/JPIA and Delta Dental to provide dental Benefits. The Contract, together with this booklet, forms the terms and conditions of the Benefits you are provided.

Covered Services - those dental services to which Delta Dental will apply Benefit payments, according to the Contract.

Deductible - the amount you must pay for dental care each year before Delta Dental's Benefits begin.

Delta Dental Dentist - a dentist who has signed an agreement with Delta Dental or a Participating Plan, agreeing to provide services under the terms and conditions established by Delta Dental or the Participating Plan.

Delta Dental PPOSM Dentist - a Delta Dental Dentist who meets the criteria for the Delta Dental PPO plan and has made a special agreement with Delta Dental to participate in this plan, or a Delta Dental Dentist who specializes in oral surgery, endodontia and periodontia.

Dependent - a Primary Enrollee's Dependent who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

Effective Date - the date this plan starts.

Enrollee - A Primary Enrollee or Dependent enrolled to receive Benefits.

Maximum - the greatest dollar amount Delta Dental will pay for covered procedures in any calendar year or lifetime for Orthodontic Benefits.

Participating Plan - Delta Dental and any other member of the Delta Dental Plans Association with whom Delta Dental contracts for assistance in administering your Benefits.

Primary Enrollee - any group member or employee who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

Single Procedure – a dental procedure to which a separate Procedure Number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

Usual, Customary and Reasonable (UCR) -

A Usual fee is the amount which an individual dentist regularly charges and receives for a given service or the fee actually charged, whichever is less.

A Customary fee is within the range of usual fees charged and received for a particular service by dentists of similar training in the same geographic area.

A Reasonable fee schedule is reasonable if it is "usual" and "customary". Additionally, a specific fee to a specific patient is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty, of the case in question.

WHO IS COVERED?

All active employees are eligible to enroll and will receive Benefits on the first day of the month following two (2) months of continuous full-time employment. Eligible Employees who retire from the water district are eligible to continue enrollment in this dental health care plan.

If you are an Enrollee and the required monthly contributions are paid, you may be covered while you take a short-term leave of absence your employer allows. This time period may be extended if required by law.

Coverage is reinstated on the day employment is resumed for Enrollees that are members of the National Guard or a military reserve unit absent from work due to active military duty. Any waiting period applied as a result of an Enrollee's absence from active employment due to service in the National Guard or military reserve unit shall be waived.

Family and Medical Leave Act of 1993: You can continue your coverage if you take a leave governed by the Family and Medical Leave Act of 1993. If you do not continue your coverage during the governed leave, it will be reinstated at the same Benefit level you received before your leave.

Uniformed Services Employment and Re-employment Rights Act of 1994: You can continue coverage for up to 24 months, if you take a leave governed by the Uniformed Services Employment and Re-employment Rights Act of 1994. If you make this election, you must submit any Premiums necessary, which may include administrative costs, to your employer. If you do not continue your coverage during a military leave, it will be reinstated at the same Benefit level you received before your leave.

WHO ARE YOUR ELIGIBLE DEPENDENTS?

- Your legal spouse.
- Your domestic partner under a legally registered and valid domestic partnership.

Domestic partners are defined as same sex partners, who are both at least 18 years of age, and opposite sex partners when one or both partners are over the age of 62. Domestic partners may be required to provide ACWA/JPIA with a copy of the Declaration of Domestic Partnership registered with the Secretary of State of the State of California.

A domestic partner is subject to the same terms and conditions as any other Dependent enrolled under this plan.

- Your dependent children until their 26th birthday.
- A dependent child may continue eligibility if:
 - a) He or she 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;
 - b) He or she is chiefly dependent on the eligible employee for support; and

- c) Proof of Dependent's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two year period after this Dependent reaches the limiting age. Eligibility will continue as long as the Dependent relies on the eligible employee for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.

"Dependent children" also means natural children, stepchildren, children of a domestic partner, adopted children, and children for whom you are court appointed legal guardian. Adopted children become eligible on the day the child is placed in the physical custody of the employee. This coverage ends on the day following the 31st day of the physical custody, if ACWA-JPIA does not receive an enrollment form with the change adding the child. Tax-dependent grandchild, if your employer has elected to cover this dependent type.

Dependent coverage is also extended to any child who is recognized under a Qualified Medical Child Support Order (QMCSO).

No Dependent in the military service is eligible.

ENROLLING YOURSELF AND YOUR DEPENDENTS

You and your dependents have the option to enroll under the following conditions:

You can waive coverage under this plan if you show proof of coverage under any other dental plan. You and your dependents must enroll within 30 days of loss of any other coverage and provide proof of loss of any other coverage.

Employees who do not enroll within 30 days of loss of the other coverage may enroll in the District's plan only during the 2nd open enrollment period following the loss of the other coverage.

Employees who are covered by the District's plan and drop coverage without proof of replacement coverage are not eligible to re-enroll in the District's plan until the 2nd open enrollment period following loss of the other coverage.

Dependent coverage is not mandatory. But, if you enroll one dependent in the District's plan, you must enroll all your dependents.

You can waive dependent coverage with proof your dependent is covered in any other dental plan.

If you choose to drop dependent coverage in the District's dental plan without proof of replacement coverage, the dependent is not eligible to re-enroll until the 2nd open enrollment period following the loss of the other dental coverage.

You have the option to enroll a dependent child under age 4 at any time but the child must be enrolled on or immediately following their 4th birthday.

You must agree to pay your dependents' premiums through payroll deduction.

Once you or your dependents are enrolled, you must remain enrolled until the next scheduled open enrollment period or following a Qualifying Event.

Changes in coverage other than those specified above may only be made during the annual open enrollment period or following a Qualifying Event.

WHEN YOU ARE NO LONGER COVERED

If you stop working for your employer, your dental coverage will end on the last day of the month in which you stop working. Your Dependents' coverage ends when yours does, or on the last day of the month following their 26th birthday.

When the Contract between Delta Dental and ACWA/JPIA is discontinued or canceled, your coverage ends immediately.

CANCELING THIS PLAN

Delta Dental may cancel this plan only on an anniversary date (period after the plan first takes effect or at the end of each renewal period thereafter), or:

- a. If ACWA/JPIA does not make payment to Delta Dental as required by the Contract.
- b. If fewer than 10 people are reported eligible by ACWA/JPIA for all Participating Employers as eligible for three months or more.
- c. If ACWA/JPIA does not give Delta Dental a list of who is eligible.
- d. If ACWA/JPIA does not allow Delta Dental to inspect its records, if required by the group Contract between ACWA/JPIA and Delta Dental.

If you believe that this plan has been terminated or not renewed due to your health status or requirements for health care services (or that of your Dependents), you may request a review by the Director of the California Department of Managed Health Care.

If the Contract between Delta Dental and ACWA/JPIA is terminated for any cause, Delta Dental is not required to predetermine services beyond the termination date or to pay for services provided after the termination date, except for Single Procedures begun while the Contract was in effect which are otherwise Benefits under the Contract.

If this plan is canceled, you and your Dependents have no right to renewal or reinstatement of your Benefits.

YOUR BENEFITS

Your dental plan covers several categories of Benefits, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, your Delta Dental Dentist may charge you his or her Usual and Customary rate for those services. Prior to providing you dental services that are not a covered Benefit, your dentist should provide you with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service (see PREDETERMINATIONS). If you would like more information about dental coverage options, you may call our Customer Service department at 888-335-8227. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.

After you have satisfied any Deductible requirements, Delta Dental will provide payment for these services at the applicable percentage indicated in the matrix on the inside cover of this booklet up to a Maximum Amount also stated in the matrix for each Enrollee in a calendar year. Payment for Orthodontic Benefits for a dependent child is limited to a lifetime Maximum shown in the matrix.

An agreement between your employer, ACWA/JPIA and Delta Dental is required to change Benefits during the term of the Contract.

The following Benefits are limited to the applicable percentages of dentist's fees or allowances specified below. You are required to pay the balance of any such fee or allowance, known as the "patient copayment." If the dentist discounts, waives or rebates any portion of the patient copayment to the Enrollee, Delta Dental only provides as Benefits the applicable allowances reduced by the amount that such fees or allowances are discounted, waived or rebated.

I DIAGNOSTIC AND PREVENTIVE BENEFITS

Diagnostic - oral examinations (including initial examinations, periodic examinations and emergency examinations); x-rays; diagnostic casts; examination of biopsied tissue; palliative (emergency) treatment of dental pain; specialist consultation

Preventive - prophylaxis (cleaning); fluoride treatment; space maintainers

II BASIC BENEFITS

Oral surgery - extractions and certain other surgical procedures, including pre- and post-operative care

Restorative - amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)

Endodontic - treatment of the tooth pulp

Periodontic - treatment of gums and bones that support the teeth

Sealants - topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay

Adjunctive General Services - general anesthesia; I.V. sedation; office visit for observation; office visit after regularly scheduled hours; therapeutic drug injection; treatment of post-surgical complications (unusual circumstances); limited occlusal adjustment

III CROWNS, INLAYS, ONLAYS AND CAST RESTORATIONS BENEFITS

Crowns, Inlays, Onlays and Cast Restorations are Benefits only if they are provided to treat cavities that cannot be directly restored with amalgam, silicate or direct composite (resin) restorations.

IV PROSTHODONTIC BENEFITS

Construction or repair of fixed bridges, partial dentures and complete dentures are Benefits if provided to replace missing, natural teeth.

Implant surgical placement and removal and for implant supported prosthetics, including implant repair and re-cementation.

V ORTHODONTIC BENEFITS

Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly.

LIMITATIONS

1. Oral examinations are Benefits only twice in any calendar year while you are eligible under any Delta Dental plan.

2. Only the first two cleanings, fluoride treatments, or Single Procedures which include cleaning, or combination thereof, provided to an individual in a calendar year while he or she is an Enrollee under any Delta Dental plan are Benefits.

Routine prophylaxes are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Basic Benefit.

3. Full-mouth x-rays are Benefits only after five years have elapsed since any prior set of full-mouth x-rays was provided under any Delta Dental plan.

Delta Dental pays for a panoramic x-ray provided as an individual service only after five years have elapsed since any prior panoramic x-ray was provided under any Delta Dental plan.

4. Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults age 18 and over, while an Enrollee is eligible under any Delta Dental plan.

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

6. Periodontal limitations:

a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.

b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.

c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

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.

7. Sealant Benefits include the application of sealants only to permanent first molars through age eight and second molars through age 15 if they are without caries (decay) or without restorations on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.

8. Crowns, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

9. Prosthodontic appliances and implants are Benefits only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan will be made if it is unsatisfactory and cannot be made satisfactory.

Delta Dental will replace an implant, a prosthodontic appliance or an implant supported prosthesis you received under another dental plan if we determine it is unsatisfactory and cannot be made satisfactory.

We will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.

10. Delta Dental will pay the applicable percentage of the Dentist's Fee for standard cast chrome or acrylic partial denture or a standard complete denture. A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.
11. A waiting period may apply to some benefits. Waiting Periods, if any, are shown on the matrix on the inside cover of this Evidence of Coverage.
12. If Orthodontic treatment is begun before you become eligible for coverage, Delta Dental's payments will begin with the first payment due to the dentist following your eligibility date.
13. Orthodontic Benefits will be provided in two payments after the person becomes covered (the initial payment at the banding date and the second in 12 months); however, for treatment plans of less than \$500.00 or when the treatment plan is 12 months or less, one payment will be made.
14. Delta Dental's orthodontics payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.
15. X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.
16. Delta Dental will not make any payments for repair or replacement of an Orthodontic appliance furnished, in whole or in part, under this plan.
17. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and the patient is responsible for the remainder of the dentist's fee.

For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

EXCLUSIONS/SERVICES WE DO NOT COVER

Delta Dental covers a wide variety of dental care expenses, but there are some services for which we do not provide Benefits. It is important for you to know what these services are before you visit your dentist.

Delta Dental does not provide benefits for:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws.

2. Services which are provided to the Enrollee by any Federal or State Governmental Agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.
3. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and is not a covered Benefit.
4. Services 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.
5. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.
6. Any Single Procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this plan.
7. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.
8. Experimental procedures.
9. All hospital costs and any additional fees charged by the Dentist for hospital treatment.
10. Anesthesia, except for general anesthesia or I.V. sedation given by a licensed Dentist for Oral Surgery services and select Endodontic and Periodontic procedures.
11. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
12. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.
13. Replacement of existing restoration for any purpose other than active tooth decay.
14. Occlusal guards and complete occlusal adjustment.

DEDUCTIBLES

You must pay the deductible amount each calendar year shown on the matrix located on the inside cover of this Evidence of Coverage.

You are not required to pay a deductible for Diagnostic, Preventive and Orthodontic Benefits.

COVERED FEES

It is to your advantage to select a dentist who is a Delta Dental Dentist, since a lower percentage of the dentist's fees may be covered by this plan if you select a dentist who is not a Delta Dental Dentist.

A list of Delta Dental Dentists (see DEFINITIONS) is available online at deltadentalins.com or by calling 1-888-335-8227.

Payment to a Delta Dental PPO Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, the dentist's accepted Usual, Customary and Reasonable Fee on file with Delta Dental,

or a fee which the dentist has contractually agreed upon with Delta Dental to accept for treating enrollees under this plan.

Payment to a Delta Dental Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the accepted Usual, Customary and Reasonable fee that the dentist has on file with Delta Dental.

Payment to a California dentist, or an out-of-state dentist, who is not a Delta Dental Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the fee which satisfies the majority of Delta's Dentists.

Payment to a dentist located outside the United States will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the fee which satisfies the majority of Delta's dentists.

CHOICE OF DENTISTS AND PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

More than 29,000 dentists in active practice in California are Delta Dental Dentists. About 16,500 of these Delta Dental Dentists are also Delta Dental PPO Dentists. You are free to choose any dentist for treatment, but it is to your advantage to choose a Delta Dental Dentist. This is because his or her fees are approved in advance by Delta Dental. Delta Dental Dentists have treatment forms on hand and will complete and submit the forms to Delta Dental free of charge.

If you choose a Delta Dental PPO Dentist, you will receive all of the advantages of going to a Delta Dental Dentist, and you may have a higher level of Benefits for certain services.

If you go to a non-Delta Dental Dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental Dentists may be submitted to Delta Dental at the address listed on page 1.

Dentists located outside the United States are not Delta Dental Dentists. Claims submitted by out-of-country dentists are translated by Delta Dental staff and the currency is converted to U.S. dollars. Claims submitted by out-of-country dentists for patients residing in California are referred to Delta Dental's Quality Assessment department for processing. Delta Dental may require a clinical examination to determine the quality of the services provided, and Delta Dental may decline to reimburse you for Benefits if the services are found to be unsatisfactory.

A list of Delta Dental PPO Dentists and Delta Dental Dentists can be obtained by calling 1-888-335-8227. This list will identify those dentists who can provide care for individuals who have mobility impairments or have special health care needs. You can obtain specific information about Delta Dental PPO Dentists and Delta Dental Dentists by using our web site – deltadentalins.com or calling the Delta Dental's Customer Service Department at the number listed on page 1. A printed list of the Delta Dental PPO Dentists and Delta Dental Dentists in your area is also available by calling 1-888-335-8227.

Services may be obtained from any licensed dentist during normal office hours. Emergency services are available in most cases through an emergency telephone exchange maintained by the local dental society that is listed in the local telephone directory.

Services from dental school clinics may be provided by students of dentistry or instructors who are not licensed by the State of California.

Delta Dental shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta Dental cannot ensure your dentist's use of precautions against the spread of such diseases, or compel your dentist to be tested for HIV or to disclose

test results to Delta Dental, or to you. Delta Dental informs its panel dentists about the need for clinical precautions as recommended by recognized health authorities on this issue. If you should have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

CONTINUITY OF CARE

Current Enrollees:

Current Enrollees may have the right to the benefit of completion of care with their terminated Delta Dental Dentist for certain specified dental conditions. Please call Delta Dental's Quality Assessment Department at (415) 972-8300 to see if you may be eligible for this benefit. You may request a copy of the Delta Dental's Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Delta Dental Dentist. We are not required to continue your care with that dentist if you are not eligible under our policy or if we cannot reach agreement with your terminated Delta Dental Dentist on the terms regarding your care in accordance with California law.

New Enrollees:

A new Enrollee may have the right to the qualified benefit of completion of care with their non-Delta Dental Dentist for certain specified dental conditions. Please call Delta Dental's Quality Assessment Department at (415) 972-8300 to see if you may be eligible for this benefit. You may request a copy of the Delta Dental's Continuity of Care Policy. You must make a specific request to continue under the care of your current provider. We are not required to continue your care with that dentist if you are not eligible under our policy or if we cannot reach agreement with your non-Delta Dental Dentist on the terms regarding your care in accordance with California law. This policy does not apply to new enrollees of an individual subscriber contract.

PUBLIC POLICY PARTICIPATION BY ENROLLEES

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communications from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Delta Dental of California, Customer Service Department, P. O. Box 997330, Sacramento, CA 95899-7330.

SAVING MONEY ON YOUR DENTAL BILLS

You can keep your dental expenses down by practicing the following:

- ✓ Comparing the fees of different dentists;
- ✓ Using a Delta Dental Dentist;
- ✓ Having your dentist obtain predetermination from Delta Dental for any treatment over \$300;
- ✓ Visiting your dentist regularly for checkups;
- ✓ Following your dentist's advice about regular brushing and flossing;
- ✓ Avoiding putting off treatment until you have a major problem; and
- ✓ Learn the facts about overbilling. Under this plan, you must pay the dentist your copayment share (see "Your Benefits" above). You may hear of some dentists who offer to accept insurance payments as "full payment." You should know that these dentists may do so by overcharging your

plan and may do more work than you need, thereby increasing plan costs. You can help keep your dental Benefits intact by avoiding such schemes.

YOUR FIRST APPOINTMENT

During your first appointment, be sure to give your dentist the following information:

- ✓ Your Delta Dental group number shown on the matrix;
- ✓ The employer's name;
- ✓ Primary Enrollee's ID number (which must also be used by Dependents);
- ✓ Primary Enrollee's date of birth;
- ✓ Any other dental coverage you may have.

ACCESSIBILITY AND SERVICES FOR AFTER-HOURS AND URGENT CARE

If you or a family member has special needs, you should ask your dentist about accessibility to their office or clinic at the time you call for an appointment. Your dentist will be able to tell you if their office is accessible taking into consideration the specific requirements of your needs.

Routine or urgent care may be obtained from any licensed dentist during their normal office hours. Delta Dental does not require prior authorization before seeking treatment for urgent or after-hours care. You may plan in advance, for treatment for urgent, emergency or after-hours care by asking your dentist how you can contact the dentist in the event you or a family member may need urgent care treatment or treatment after normal business hours. Many dentists have made prior arrangements with other dentists to provide care to you if treatment is immediately or urgently needed. You may also call the local dental society that is listed in your local telephone directory if your dentist is not available to refer you to another dentist for urgent, emergency or after-hours care.

PREDETERMINATIONS

After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than \$300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are eligible and meet all the requirements of your plan at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send a claim to us listing the proposed treatment. Delta Dental will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the statement to us for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual maximum when completed services are submitted to Delta Dental.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

REIMBURSEMENT PROVISIONS

Delta Dental will pay Delta Dental Dentists directly. Delta Dental of California's agreement with our Delta Dental Dentists makes sure that you will not be responsible to the dentist for any money we owe. However, if for any reason we fail to pay a dentist who is not a Delta Dental Dentist, you may be liable for that portion of the cost. If you have selected a non-Delta Dental Dentist, Delta Dental will pay you. Payments made to you are not assignable (in other words, we will not grant requests to pay non-Delta Dental Dentists directly).

Payment for claims exceeding \$500 for services provided by dentists located outside the United States may, at Delta Dental's option, be conditioned upon a clinical evaluation at Delta Dental's request (see Second Opinions). Delta Dental will not pay Benefits for such services if they are found to be unsatisfactory.

Delta Dental does not pay Delta Dental Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service. If you wish to know more about the method of reimbursement to Delta Dental Dentists, you may call Delta Dental's Customer Service Department for more information.

Payment for any Single Procedure which is a Covered Service will only be made upon completion of that procedure. Delta Dental does not make or prorate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any Deductible (and determines when a charge is made against any Maximum) under your plan.

If there is a difference between what your dentist is charging you and what Delta Dental says your portion should be, or if you are not satisfied with the dental work you have received, contact Delta Dental's Customer Service Department. We may be able to help you resolve the situation.

Delta Dental may deny payment of any claim for services submitted more than 12 months after the date the services were provided. If a claim is denied due to a Delta Dental Dentist's failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by Delta Dental (unless you failed to advise the dentist of your eligibility at the time of treatment).

The process Delta Dental uses to determine or deny payment for services is distributed to all Delta Dental Dentists. It describes in detail the dental procedures covered as Benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the plan. Claims are reviewed for eligibility and are paid according to these processing policies. Those claims which require additional review are evaluated by Delta's dentist consultants. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dental Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta Dental's Customer Service Department for more information regarding Delta Dental's processing policies.

Delta Dental uses a method called "first-in/first-out" to begin processing your claims. The date we receive your claim determines the order in which processing begins. For example, if you receive dental services in January and February, but we receive the February claim first, processing begins on the February claim first.

Incomplete or missing data can affect the date the claim is paid. If all information necessary to complete claim processing has not been provided, payment could be delayed until any missing or incomplete data is received by Delta Dental.

Unless the services are exempt, you are required to pay the Deductible on the first claim for which processing is completed in a calendar year. Your Deductible is normally paid on the first service subject to a deductible listed on a claim with multiple services.

The order in which your claims are processed and paid by Delta Dental may also impact your annual Maximum. For example, if a claim with a later date of service is paid and your annual Maximum for the year has been reached then a claim with an earlier date of service in the same calendar year will not be paid.

IF YOU HAVE QUESTIONS ABOUT SERVICES FROM A DELTA DENTAL DENTIST

If you have questions about the services you receive from a Delta Dental Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call our Quality Assessment department at 415-972-8300, extension 2700. If appropriate, Delta Dental can arrange for you to be examined by one of our consulting dentists in your area. If the consultant recommends the work be replaced or corrected, Delta Dental will intervene with the original dentist to either have the services replaced or corrected at no additional cost to you or obtain a refund. In the latter case, you are free to choose another dentist to receive your full Benefit.

SECOND OPINIONS

Delta Dental obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

Delta Dental will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Predetermination of treatment cost by a dentist. Delta Dental will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. Delta Dental will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta Dental to perform the clinical examination. When Delta Dental authorizes a second opinion through a Regional Consultant, we will pay for all charges.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examination or consultant may be submitted to Delta Dental for payment. Delta Dental will pay such claims in accordance with the Benefits of the plan.

ORGAN AND TISSUE DONATION

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak to your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

GRIEVANCE PROCEDURE AND CLAIMS APPEAL

If you have any questions about the services received from a Delta Dental Dentist, we recommend that you first discuss the matter with your Dentist. If you continue to have concerns, you may call or write us. We will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. Any questions of ineligibility should first be handled directly between you and your group. If you have any question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta Dental, or the quality of dental services performed by a Delta Dental Dentist, you may call us toll-free at 1-888-335-8227, contact us on the Internet through our web site: deltadentalins.com or write us at P.O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

If your claim has been denied or modified, you may file a request for review (a grievance) with us within 180 days after receipt of the denial or modification. If in writing, the correspondence must include your group name and number, the Primary Enrollee's name and social security number, the inquirer's telephone number and any additional information that would support the claim for benefits. Your correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

Our review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of our regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Our review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and we will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract terms, we shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

We will provide the Enrollee a written acknowledgement within five calendar days of receipt of the request for review. We will make a written decision within 30 calendar days of receipt of the request for the review. We will respond, within three days of receipt, to complaints involving severe pain and imminent and serious threat to a patient's health. You may file a complaint with the Department of Managed Health Care after you have completed Delta Dental's grievance procedure or after you have been involved in Delta Dental's grievance procedure for 30 calendar days. You may file a complaint with the department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Delta Dental, your health plan, you should first telephone Delta Dental at **1-888-335-8227** and use Delta Dental's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site (<http://www.hmohelp.ca.gov>) has complaint forms, IMR application forms and instructions online.

IF YOU HAVE ADDITIONAL COVERAGE

It is to your advantage to let your dentist and Delta Dental know if you have dental coverage in addition to this Delta Dental plan. Most dental carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both plans - sometimes paying 100% of your dental bill. For example, you might have some fillings that cost \$100. If the primary carrier usually pays 80% for these services, it would pay \$80. The secondary carrier might usually pay 50% for this service. In this case, since payment is not to exceed the entire fee charged, the secondary carrier pays the remaining \$20 only. Since this method pays 100% of the bill, you have no out-of-pocket expense.

Be sure to advise your dentist of all plans under which you have dental coverage and have him or her complete the dual coverage portion of the claim form, so that you will receive all benefits to which you are

entitled. For further information, contact the Delta Dental Customer Service Department at the number in the USING THIS BOOKLET section.

OPTIONAL CONTINUATION OF COVERAGE (COBRA)

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) and the California Continuation Benefits Replacement Act (or Cal-COBRA, pertaining to employers with two to 19 employees), both require that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event and whether you are covered under federal COBRA or Cal-COBRA.

DEFINITIONS

The meaning of key terms used in this section are shown below and apply to both federal and Cal-COBRA.

Qualified Beneficiary means:

1. you and/or your Dependents who are enrolled in the Delta plan on the day before the Qualifying Event, or
2. a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

- Event 1. the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
- Event 2. your death;
- Event 3. your divorce or legal separation from your spouse;
- Event 4. your Dependents' loss of dependent status under the plan, and
- Event 5. as to your Dependents only, your entitlement to Medicare.

You means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE UNDER FEDERAL COBRA

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18 month period can be extended for a total of 29 months, provided:

1. a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and,

2. notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of tetermination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta within 30 days of any such determination.

If, during the 18-months continuation period resulting from Qualifying Event 1, your Dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4, or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your Dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title II, United States Code, benefits may be substantially reduced or eliminated for retired employees and their Dependents, or the surviving spouse of a deceased retired employee. If this Benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's Dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

PERIODS OF CONTINUED COVERAGE UNDER CAL-COBRA (groups of 2 - 19)

In the case of Cal-COBRA, Delta will act as the administrator. Notification and premium payments should be made directly to Delta. Notifications and payments should be delivered by first-class mail, certified mail, or other reliable means of delivery.

Individuals who are eligible for coverage under the federal COBRA law are not eligible for coverage under Cal-COBRA. The employer must notify Delta in writing within 30 days of the date when the employer becomes subject to COBRA.

Qualified Beneficiaries may continue coverage for 36 months following the month in which Qualifying Events 1, 2, 3, 4, or 5 occur.

If, during the 36-month continuation period resulting from Qualifying Event 1, the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on the date of the Qualifying Event or became disabled at any time during the first 60 days of continuation coverage; and notice of the determination is given to the employer during the initial period of continuation coverage and within 60 days of the date of the social security determination letter, the Qualified Beneficiary may continue coverage for a total of 36 months following the month in which Qualifying Event 1 occurs.

This period of coverage will end on the first of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. The Qualified Beneficiary must notify the employer, or administrator within 30 days of any such determination.

If, during the 36-month continuation period resulting from Qualifying Event 1, the Qualified Beneficiary experiences Qualifying Events 2, 3, 4, or 5, he or she must notify the employer within 60 days of the second Qualifying Event and has a total of 36 months continuation coverage after the date of the date of the first Qualifying Event.

Delta shall notify the Primary Enrollee of the date his or her continued coverage will terminate. This termination notification will be sent during the 180 day period prior to the end of coverage.

ELECTION OF CONTINUED COVERAGE

A Qualified Beneficiary will have 60 days from a Qualifying Event to give Delta written notice of the election to continue coverage.

Upon receipt of the written notice, Delta will provide a Qualified Beneficiary with the necessary benefits information, monthly Premium charge, enrollment forms, and instructions to allow election of continued coverage. Failure to provide this written notice of election to Delta within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial Premium to Delta, which includes the Premium for each month since the loss of coverage. Failure to pay the required Premium within the 45 days will result in the loss of the right to continue coverage, any Premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their Dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occurs:

1. The allowable number of consecutive months of continued coverage is reached;
2. Failure to pay the required Premiums in a timely manner;
3. The employer ceases to provide any group dental plan to its employees;
4. The individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or Dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
5. Entitlement to Medicare.

Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of Premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta plan.