DELTA DENTAL®

MT. DIABLO UNIFIED SCHOOL DISTRICT

Combined Evidence of Coverage and Disclosure Form



deltadentalins.com

Group Number: 07103

Divisions: 00040 and 00041

Effective Date: January 1, 2023

THIS MATRIX IS A BRIEF SUMMARY OF YOUR BENEFITS. YOU MUST READ THE ENTIRE EVIDENCE OF COVERAGE IN ORDER TO UNDERSTAND THE DETAILS OF YOUR DENTAL COVERAGE

DELTA DENTAL PPO[SM] INCENTIVE PLAN

Your Co-Payments, Maximums, Deductibles and Waiting Periods

DENTAL SERVICES	PPO DENTIST		NON-PPO DENTIST		CALENDAR YEAR MAXIMUM*	WAITING PERIOD
	DELTA DENTAL'S CO-PAYMENT	YOUR CO-PAYMENT	DELTA DENTAL'S CO-PAYMENT	YOUR CO-PAYMENT		
Diagnostic and Preventive Services	70-100%	30-0%	70-100%	30-0%	$1,700 for each Enrollee if services are provided by a Delta Dental PPO Dentist $1,500 for each Enrollee if services are provided by other dentists	None
Basic Services	70-100%	30-0%	70-100%	30-0%		None
Crowns, Inlays, Onlays, and Cast Restorations	70-100%	30-0%	70-100%	30-0%		None
Prosthodontic Services	50%	50%	50%	50%		None
Dental Accident Services	100%	0%	100%	0%	$1,000 for each Enrollee**	None
Orthodontics Services for dependent children only	50%	50%	50%	50%	$500 lifetime Maximum	None

* In-Network - (using Delta Dental PPO provider) $200 additional annual Maximum and claims paid at incentive level of member (exception: prosthodontics 50%).
Out-of-Network - (using Delta Dental Premier® provider) claims paid at members' incentive level without additional $200 annual maximum (exception: prosthodontics 50%).

** This Benefit is separate from the other Benefits.

Note: If you transfer or move from one Delta Dental plan to another, you do not receive a new calendar year Maximum because you transferred or moved. The Maximum amount for Benefits paid by Delta Dental in a calendar year under both plans will not exceed the Maximum allowed under your current plan.

For example: If Delta Dental paid $500 in Benefits while you were enrolled in a previous plan and the Maximum amount of your current plan is $1,000 the total amount Delta Dental will pay for your Benefits under the current plan is $500.

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 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, CA 94105

For claims, eligibility and benefits inquiries, or additional information, call Delta Dental's Customer Service department toll-free at: 866-499-3001 or contact us on our website: 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/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.

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

Contract - the written agreement between your employer or sponsoring group 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.

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 PPO Dentist - a Dentist with whom Delta Dental has a written agreement to provide services at the in-network level for Enrollees in this Delta Dental PPO Plan.

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 and 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.

Premiums - the money paid each month for you and your Dependents' dental coverage.

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 Enrollee is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty, of the case in question.

WHO IS COVERED?

All benefit-eligible employees hired on or before the 15th day of the month are eligible for this plan on the first day of the month following the month in which their employment begins. All benefit-eligible employees hired after the 15th day of the month are eligible for this plan on the first day of the month following one month of employment. However, at the beginning of each fiscal year (July 1), new employees starting in the months of July or August and receiving a paycheck in the months of July or August, regardless of the hire date, are eligible for this plan the first day of the following month in which their employment begins.

Retirees are also eligible in this plan.

WHO ARE YOUR ELIGIBLE DEPENDENTS?

- Your legal spouse; and
- 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, adopted children, children placed for adoption and foster children.

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 YOUR DEPENDENTS

Your Dependents must be enrolled when you first become eligible or on the first day of the month after they become Dependents.

WHEN YOU ARE NO LONGER COVERED

1. 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 as soon as they are no longer Dependents.

2. When the Contract between Delta Dental and your employer is discontinued or canceled, your coverage ends immediately.

3. When you are on strike, layoff or leave of absence, Delta Dental does not cover any dental services received by you or your Dependents.

The following options may be offered if your eligibility ends:

1. **If you transfer from one school incentive plan to another**

   If you transfer from one school or school district's incentive plan to another incentive plan provided by a school or school district, your Benefits and annual Maximum may be affected in the following ways:

   If there is a break in coverage between the two plans, the Applicable Percentage for Basic Benefits starts at 70%. But you and your Dependents qualify for the full annual Maximum provided under your current plan. The amounts paid under your previous plan do not reduce the annual Maximum paid under your current plan.

   If there is no break in coverage between the two plans, you retain the Applicable Percentage for Basic Benefits you reached under your prior plan. But you do not qualify for any additional Maximum amounts. The Maximum amount your dental plan pays in a calendar year under both plans will not exceed the amount paid under your current plan.

   Your dental history with Delta Dental moves with you when you transfer from one school's incentive plan to another incentive plan provided by a school or school district. For example if both plans cover two cleanings in a calendar year and transfer from one plan to another, you do not qualify for four cleanings in a calendar year.

2. **Approved leave of absence**

   If you go on an approved leave of absence, you may continue your coverage for yourself and your Dependents for a maximum of one year by paying the School District each month for the coverage. Your School District's administrative office can tell you how much the continued coverage will cost.

   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 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 selection, 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.

3. **Labor dispute**

If you stop working because of a labor dispute (a strike, for example), you can continue your coverage for up to six months from the date you stopped work, as long as at least 75% of the absent employees at your workplace choose to keep their coverage for themselves and their Dependents. If you choose this option, you must make the appropriate monthly payment to the School District or your employee association.

If you lose eligibility because of a labor dispute, and then return to work, your eligibility will begin again on the first day of the month following your return to work. Your coverage will then be the same as that for a new employee, unless the School District makes retroactive payment (payment for past months that you were not working) for all employees who would have been eligible except for the labor dispute. These employees' future coverage would then be the same as if there had been no break in eligibility. However, any services that were provided to these employees and their Dependents during the time they were not eligible would not be covered.

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 any time if payments required by the Contract are not made to Delta Dental.

If the Contract 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 plan covers several categories of Benefits when the services are provided by a licensed dentist and 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.

The Maximum amount paid each calendar year by Delta Dental for Diagnostic, Preventive, Basic, Restorative, Crown and Prosthodontic Benefits is:
$1,700 for each Enrollee if services are provided by a Delta Dental PPO Dentist; or
$1,500 for each Enrollee if services are provided by other dentists.

In-Network - (using Delta Dental PPO provider) $200 additional annual Maximum and claims paid at incentive level of member (exception: prosthodontics 50%).

Out-of-Network - (using Delta Dental Premier provider) claims paid at members incentive level without additional $200 annual maximum (exception: prosthodontics 50%).

If you transfer or move from one Delta Dental plan to another, you will not receive a new calendar year Maximum because of the transfer or move. The Maximum amount for Benefits paid by Delta Dental in a calendar year under both plans will not exceed the Maximum allowed under your current plan.

For example: If Delta Dental paid $500 in Benefits while you were enrolled in a previous plan and the Maximum amount of your current plan is $1,000, the total amount Delta Dental will pay for your Benefits under the current plan is $500.

Orthodontic Benefits for a dependent child is limited to a lifetime Maximum of $500.

The Maximum amount paid by Delta Dental for each Enrollee each calendar year for Dental Accident Benefits is $1,000. This Benefit is separate from the other Benefits.

Delta Dental will pay 70% of the Covered Fees for the Diagnostic, Preventive, Basic, Crowns and Restorative Benefits during the first calendar year of eligibility.

This percentage increases 10% each consecutive year the dentist is visited to a maximum of 100%. If you do not use your plan, the percentage remains at the level you reached the previous year. It drops back to 70% if you lose eligibility and then become eligible again.

The percentages for Prosthodontic, Dental Accident, and Orthodontic Benefits do not change each year you visit your dentist.

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 "Enrollee co-payment." If the dentist discounts, waives or rebates any portion of the patient co-payment 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.

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

Although the levels (i.e. percentages) of Benefits are the same no matter what dentist you choose, your out-of-pocket expenses may differ depending upon whether you select a Delta Dental PPO Dentist. When receiving treatment from a non-Delta Dental PPO Dentist, you will have potentially greater out-of-pocket expenses.

I. DIAGNOSTIC AND PREVENTIVE BENEFITS

70-100% if provided by a Delta Dental PPO Dentist
70-100% if provided by other dentists

Diagnostic - oral 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

70-100% if provided by a Delta Dental PPO Dentist
70-100% if provided by other dentists

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; 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 RESTORATION BENEFITS

70-100% if provided by a Delta Dental PPO Dentist
70-100% if provided by other dentists

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

IV. PROSTHODONTIC BENEFITS

50% if provided by a Delta Dental PPO Dentist
50% if provided by other dentists

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. DENTAL ACCIDENT BENEFITS

100% if provided by a Delta Dental PPO Dentist
100% if provided by other dentists

Any services which would be covered under other Benefit categories (subject to the same limitations and exclusions) are covered when they are provided for conditions caused directly by external, violent and accidental means.

VI. ORTHODONTIC BENEFITS

50% if provided by a Delta Dental PPO Dentist
50% if provided by other dentists
(Division 00038 is not eligible for Orthodontic Benefits)

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

LIMITATIONS

1. An oral examination is a Benefit only twice in any calendar year while you are eligible under any Delta Dental plan.

2. Full-mouth x-rays are a Benefit once in a five-year period while you are eligible under any Delta Dental plan.

3. 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 you are eligible under any Delta Dental plan.

4. We pay for two cleanings or a dental procedure that includes a cleaning each calendar year under any Delta Dental plan.

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

5. Fluoride treatments are covered twice each calendar year under any Delta Dental 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.
   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 planning 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 are limited to eligible dependent children under age 14. Sealant Benefits include the application of sealants only to permanent posterior molars without caries (decay), without restorations and with the occlusal surface intact. Sealant Benefits do not include the repair or replacement of a sealant on a tooth within three 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 a standard partial or complete denture. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth which is made from accepted materials and by conventional methods.

11. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are 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.

12. Delta will pay Dental Accident Benefits when services are provided within 180 days following the date of accident and shall not include any services for conditions caused by an accident occurring before your eligibility date.

13. Orthodontic coverage is limited to eligible dependent children.

14. If orthodontic treatment is begun before you become eligible for coverage, Delta's payments will begin with the first payment due to the dentist following your eligibility date.

15. Delta'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.

16. Delta will pay the applicable percentage of the Dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If the Enrollee selects specialized orthodontic appliances or procedures chosen for aesthetic considerations an allowance will be made for the cost of a standard orthodontic treatment plan and the patient is responsible for the remainder of the Dentist's fee.

17. X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.

EXCLUSIONS/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 or conditions that are covered under 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. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

10. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.

11. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

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. Intravenous sedation, occlusal guards and complete occlusal adjustment.

15. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this plan.

OTHER CHARGES

Delta Dental's co-payment for your Benefits is shown in this Evidence of Coverage under the caption titled "YOUR BENEFITS." If dental services are provided by a Delta Dental Dentist or a Delta Dental PPO Dentist, you are responsible for your co-payment only. If the dental services you receive are provided by a dentist who is not a Delta Dental Dentist or Delta Dental PPO Dentist, you are responsible for the difference between the amount Delta Dental pays and the amount charged by the non-Delta Dental dentist.

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 using our website -deltadentalins.com, or by calling 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 for services by 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 that satisfies the majority of Delta Dental Dentists.

Payment for services by 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 that satisfies the majority of Delta Dental 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.

Nearly 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. While covered under the PPO plan, 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 P.O. Box 997330, Sacramento, CA 95899-7330.

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 Enrollees 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 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 also obtain specific information about Delta Dental PPO Dentists and Delta Dental Dentists by using our website – deltadentalins.com or calling the Delta Dental Customer Service department at the number shown on page 1.

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 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 communication 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:

1. Compare the fees of different dentists;

2. Use a Delta Dental Dentist;

3. Have your dentist obtain predetermination from Delta Dental for any treatment over $300;

4. Visit your dentist regularly for checkups;

5. Follow your dentist's advice about regular brushing and flossing;

6. Avoid putting off treatment until you have a major problem; and

7. Learn the facts about overbilling. Under this plan, you must pay the dentist your co-payment share (see YOUR BENEFITS). 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:

1. Your Delta Dental group number (on the front of this booklet);

2. The employer's name;

3. Primary Enrollee's ID number (which must also be used by Dependents);

4. Primary Enrollee's date of birth; and

5. 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 form 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 form 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 individual is eligible. Payment will depend on the individual'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

A Delta Dental Dentist will file the claim for you. You do not have to file a claim or pay Delta Dental's co-payment for covered services if provided by a Delta Dental Dentist. 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.

If the covered service is provided by a dentist who is not a Delta Dental Dentist, you are responsible for filing the claims and paying your dentist. Claims should be filed with Delta Dental of California at P. O. Box 997330, Sacramento, CA 95899-7330 and Delta Dental will reimburse you. 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. 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 that 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 a 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 Dental'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 you or your dentist has not provided Delta Dental with all information necessary to complete claim processing, payment could be delayed until any missing or incomplete data is received by Delta Dental.

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.

Maximums can also be affected when the amount paid for services provided by Delta Dental PPO Dentists is higher than the maximum paid for services provided by a dentist who is not a Delta Dental PPO dentist. For example, if the Delta Dental PPO Plan's annual Maximum is $1,200 and the maximum for services provided by a dentist who is not a Delta Dental PPO dentist is $1,000 and Delta Dental has paid $1,000 or more dollars for covered dental services, you do not qualify for any further payments for services provided by a dentist who is not a Delta Dental PPO dentist. But, if any other covered services are provided by a Delta Dental PPO Dentist, you qualify for an additional $200.

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 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 person 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 a 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, he or she may call us toll-free at **866-499-3001**, contact us on our website at: 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 with us within 180 days after receipt of the denial or modification. We will treat the request for review as a grievance. If in writing, the correspondence must include the group name and number, the Primary Enrollee's name and ID number, the inquirer's telephone number and any additional information that would support the claim for benefits.

The 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 you 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 a written acknowledgement within five days of receipt of the request for review. We will render a decision and respond to you within 60 days of receipt of the request for review. We will respond, within 72 hours to grievances involving severe pain and imminent and serious threat to a patient's health (urgent care grievance).

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.

DUAL COVERAGE BETWEEN INCENTIVE PLANS

Coverage under two plans is called dual coverage. If your spouse is covered under your plan as your Dependent but obtains coverage as an employee under another school or school district's incentive plan as well, the Applicable Percentage for Basic Benefits for the spouse begins at 70%. The percentage paid under the plan covering them as a Dependent does not carry over to the plan covering the spouse as an employee. However, the incentive level of the plan covering the Enrollee as a Dependent remains at the attained level.

Plan Arranged By:

Keenan and Associates
Oakland, CA 94607