

DeltaCare[®] USA

Dental Health Care Program
for Eligible Employees
and Dependents

The Boeing Company

*Combined Evidence of Coverage
and Disclosure Form*

Provided by:

Delta Dental of California
12898 Towne Center Drive
Cerritos, CA 90703-8579
800-422-4234

www.deltadentalins.com/deltacareusa

THE BOEING COMPANY

Baseline/Nonunion

Actives

Nonunion Salaried

BNA Nonunion Low Cost Subsidiary—Albuquerque, New Mexico

BNA Nonunion Low Cost Subsidiary—El Paso, Texas (Salaried employees)

BNA Nonunion Low Cost Subsidiary—Heath, Ohio and Corinth/Irving,
Texas (Salaried employees)

BNA Nonunion Low Cost Subsidiary—(various locations)

BNA Nonunion Low Cost Subsidiary—Richardson, Texas

SVS

Jeppesen

Seabrook (salaried exempt employees)

San Antonio (salaried employees)

Seabrook (salaried, nonexempt employees)

San Antonio (hourly employees)

Divested Group: ULA

Divested Group: ULS

Noble Tec Corporation

Data Plan

C-Map (effective 07/01/2007)

Satellite Development Center (Nonunion)

Spectrolab Nonunion

SBS International

Boeing Advanced Information System - Maryland Operations

Alteon Training, LLC

To confirm coverage of one of the eligible populations listed above, please contact the Plan Administrator or The Boeing Service Center.

For questions or information regarding your coverage please contact Delta Dental of California's Customer Service department at 800-422-4234 by referring to the group contract name on the outside cover of this booklet.

The summary plan description for this Plan is The Boeing Company Health and Welfare Plans booklet for the eligible population, any applicable provider directory and this coverage-specific brochure issued by Delta Dental of California.

For detailed information concerning employee and dependent eligibility, enrollment, contributions, coverage terminations, leaves of absence provisions, eligibility reviews and appeals, Qualified Medical Child Support Orders (QMCSO), ERISA Special Disclosures and other general plan information, refer to The Boeing Health and Welfare Plans Summary Plan Description, which supercedes any eligibility information contained in this document, or contact the plan administrator.

The health plan benefit description is incorporated as part of The Boeing Summary Plan Description.

EVIDENCE OF COVERAGE DISCLOSURE FORM

DeltaCare USA Dental HMO Program

This booklet is a Combined Evidence of Coverage and Disclosure Form (“EOC”) for your DeltaCare USA Dental HMO Program (“Program”) provided by Delta Dental of California (“Delta Dental”). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract (“Contract”) issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED “SPECIAL NEEDS”.

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

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services, and who has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as defined by the Client.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

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

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term. The Client determines enrollment dates for new hires, mid-year enrollment and open enrollment.

Out-of-Network means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.

Preauthorization means the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

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

Service Area means the state of California.

Special Health Care Need means a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are 1) the Enrollee's inability to obtain access to the assigned Contract Dentist's facility because of a physical disability and 2) the Enrollee's inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

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

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

We, Us or Our means Delta Dental of California.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

- 1) the date you are eligible for coverage;
- 2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

- 1) spouse (unless legally separated or divorced);
- 2) unmarried children from birth up to the limiting age as defined by the Client;
- 3) unmarried children beyond the limiting age if they are wholly dependent on you for support and are Full-Time Students.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within the period specified in the Boeing Health and Welfare Plan Summary Plan Description. Legally adopted children (other than newborns) are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee for adoption.

The client will advise Delta Dental if a dependent is eligible for Qualified Medical Child Support Order coverage and the effective date of coverage under this type of order.

An unmarried dependent child may continue eligibility if:

- 1) he or she is incapable of self-support because of a physical disability or mental incapacity that began prior to reaching the limiting age;
- 2) he or she is chiefly dependent on you for support; and
- 3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a physical disability or mental incapacity that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Prepayment Fees/Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-442-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY DELTA DENTAL, OR FOR EMERGENCY SERVICES AS PROVIDED IN *EMERGENCY SERVICES*. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

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

Continuity of Care

Current Enrollees:

You may have the right to the benefit of completion of care with your terminated Dentist for certain specified dental conditions. Please call Customer Service at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated 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 Dentist on the terms regarding your care in accordance with California law.

New Enrollees:

You may have the right to the qualified benefit of completion of care with an Out-of-Network Dentist for certain specified dental conditions. Please call Customer Service at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current 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 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.

Special Needs

If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at 800-422-4234. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-422-4234.

Benefits, Limitations and Exclusions

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

Copayments and Other Charges

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

Emergency Services

If Emergency Services are needed, you should contact your Contract Dentist whenever possible. If you are a new Enrollee and do not have an assigned Contract Dentist yet, and you need Emergency Services, you should contact Delta Dental's Customer Service department at 800-422-4234 for help in locating a Contract Dentist. Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

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

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

You can receive your covered out-of-network emergency dental care when you are outside of the United States through a partnership between Delta Dental and International SOS Assistance, Inc. (I-SOS). I-SOS provides referrals to 3,200 dentist or dental clinics in nearly 200 countries worldwide. English-speaking operators are available around the clock to help you find a dentist. For more information, check our web site at www.deltadentalins.com/deltacareusa or call 800-523-6586 from the U.S. Once you leave the U.S., you can call I-SOS at 215-942-8226 - collect.

When you see an I-SOS dentist, you must pay for your treatment at the time of service and get a detailed receipt from the dentist. In addition to providing the dentist's name and address (including country), this receipt should describe the services performed by the dentist and indicate the tooth or teeth that were treated. It should also indicate whether the dentist's charges were billed in U.S. dollars or another currency.

Once we receive your claim, we will reimburse you subject to the terms and conditions of your DeltaCare USA coverage. Reimbursement is based on the out-of-network emergency benefit provided through your group plan, noted above. As with any dental plan, this reimbursement may not cover the entire cost of the treatment rendered.

Specialist Services

Specialist and Orthodontic Services must be referred by the assigned Contract Dentist and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and *Limitations and Exclusions* to determine which procedures are covered under this Program.

Second Opinion

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

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 800-422-4234 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the plan or with the Department of Managed Health Care. Refer to pages 8-9 for information on Enrollee Complaint Procedures.

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 180 days of the end of treatment. Valid claims received after the 180 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Delta Dental, 12898 Towne Center Drive, Cerritos, CA 90703.

Provider Compensation

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

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown on the back cover of this booklet.

Processing Policies

The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental Program are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits

paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call Delta Dental's Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
MS: QM600
12898 Towne Center Drive
Cerritos, CA 90703-8579

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta Dental within at least 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a 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, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 5 calendar days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. We will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a

complaint with the California Department of Managed Health Care. 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 your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **800-422-4234** and use your health plan'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 an 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.

IMR has limited application to your dental program. You may request an IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210. For additional information, refer to the Boeing Health and Welfare Plans Summary Plan Description.

Standing Committee on Public Policy

A six member committee, comprised of one Dentist, four representatives from the purchaser and subscriber community and one member of the Delta Dental Board of Directors, meets quarterly and participates in establishing policies to assure the comfort, dignity, and convenience of Enrollees and the public. Issues may be presented to this committee by writing to Delta Dental's Public Policy Committee, c/o Professional Relations, at the address on the back of this booklet.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such

person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Enrollee Complaint Procedure* or the *Optional Continuation of Coverage (COBRA)* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

- 1) End of month upon loss of eligibility as described in this Evidence of Coverage;
or
- 2) Upon 15 days written notice if:
 - a) an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
 - b) the premiums are not paid by or on behalf of the Enrollee on the date due. However, the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
 - c) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under the Program;
- 3) Upon 30 days written notice if the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of this Contract upon payment of all delinquent charges;
- 4) Upon 90 days written notice if the contract is terminated or not renewed.

Cancellation of a Primary Enrollee's enrollment, as described above, shall automatically cancel the enrollment of any of his or her Dependent Enrollees. Any cancellation is subject to the written notification requirements set forth in the Contract.

If you believe that enrollment has been cancelled or not renewed because of your health status or requirements for health care services, or that of your dependent(s), you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to *Enrollee Complaint Procedure* on pages 8-9.

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 the Enrollee is covered under federal COBRA or Cal-COBRA.

DEFINITIONS

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

Qualified Beneficiary means:

- 1) you and/or your dependents who are enrolled in the DeltaCare USA/Delta Dental 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 dependent's loss of dependent status under the plan; and
- Event 5. as to your dependents only, your entitlement to Medicare.

You or **your** 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 the determination.

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 Dental 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.

Under federal COBRA law only, when an employer has filed for bankruptcy under Title 11, 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 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 Dental will act as the administrator. Notification and premium payments should be made directly to Delta Dental. 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 Dental 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 Dental 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

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in 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 his or her employer, 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 loss of the right to continue coverage and 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 occur:

- 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 moves out of the plan's service area;

- 5) 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
- 6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental 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 Dental 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 Dental plan.

Organ and Tissue Donation

Donating organs 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 with 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.

SCHEDULE A
Description of Benefits and Copayments

The benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions and governing administrative policies of the program. Please refer to *Schedules B and C* for further clarification of benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2007 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient - <i>limited to 2 per calendar year</i>	No Cost
D0140	Limited oral evaluation - problem focused - <i>limited to 2 per calendar year</i>	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.....	No Cost
D0150	Comprehensive oral evaluation - new or established patient - <i>limited to 2 per calendar year</i>	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report - <i>limited to 2 per calendar year</i>	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) - <i>limited to 2 per calendar year</i>	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient - <i>limited to 2 per calendar year</i>	No Cost
D0210	Intraoral <i>radiographs</i> - complete series (including bitewings) - <i>limited to 1 series every 36 months</i>	No Cost
D0220	Intraoral - periapical first film.....	No Cost
D0230	Intraoral - periapical each additional film.....	No Cost
D0240	Intraoral - occlusal film.....	No Cost
D0270	Bitewing <i>radiograph</i> - single film - <i>limited to 2 per calendar year</i>	No Cost
D0272	Bitewings <i>radiographs</i> - two films - <i>limited to 2 per calendar year</i>	No Cost
D0273	Bitewings <i>radiographs</i> - three films.....	No Cost

D0274	Bitewings radiographs - four films - limited to 2 per calendar year	No Cost
D0330	Panoramic film.....	No Cost
D0460	Pulp vitality tests.....	No Cost
D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services)	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis cleaning - adult - 1 per 4 month period	No Cost
D1120	Prophylaxis cleaning - child - 1 per 4 month period	No Cost
D1203	Topical application of fluoride (prophylaxis not included) - child - to age 19; 2 per calendar year	No Cost
D1204	Topical application of fluoride (prophylaxis not included) - adult.....	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - 2 per calendar year	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - limited to permanent molars to age 14	No Cost
D1510	Space maintainer - fixed - unilateral.....	No Cost
D1515	Space maintainer - fixed - bilateral.....	No Cost
D1520	Space maintainer - removable - unilateral	No Cost
D1525	Space maintainer - removable - bilateral	No Cost

D2000-D2999 III. RESTORATIVE - (There is an additional \$10 per visit copayment for all non diagnostic/preventive visits)

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior.....	No Cost
D2332	Resin-based composite - three surfaces, anterior.....	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2750	Crown - porcelain fused to high noble metal.....	\$180.00
D2751	Crown - porcelain fused to predominantly base metal	\$165.00
D2752	Crown - porcelain fused to noble metal.....	\$177.00
D2780	Crown - ¾ cast high noble metal	\$180.00
D2781	Crown - ¾ cast predominantly base metal.....	\$169.00
D2782	Crown - ¾ cast noble metal	\$177.00

D2790	Crown - full cast high noble metal.....	\$180.00
D2791	Crown - full cast predominantly base metal	\$150.00
D2792	Crown - full cast noble metal.....	\$172.00
D2794	Crown - titanium.....	\$180.00
D2910	Recement inlay, onlay or partial coverage restoration.....	No Cost
D2915	Recement cast or prefabricated post and core.....	No Cost
D2920	Recement crown.....	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2940	Sedative filling	No Cost
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2970	Temporary crown (fractured tooth) - <i>palliative treatment only</i>	No Cost

D3000-D3999 IV. ENDODONTICS - (*There is an additional \$10 per visit copayment for all non diagnostic/preventive visits*)

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3310	<i>Root canal</i> - anterior (excluding final restoration)	No Cost
D3320	<i>Root canal</i> - bicuspid (excluding final restoration)	No Cost
D3330	<i>Root canal</i> - molar (excluding final restoration).....	No Cost
D3346	Retreatment of previous root canal therapy - anterior	No Cost
D3347	Retreatment of previous root canal therapy - bicuspid	No Cost
D3348	Retreatment of previous root canal therapy - molar	No Cost
D3410	Apicoectomy/periradicular surgery - anterior.....	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	No Cost
D3425	Apicoectomy/periradicular surgery - molar (first root)	No Cost
D3426	Apicoectomy/periradicular surgery (each additional root).....	No Cost
D3430	Retrograde filling - per root	No Cost

D4000-D4999 V. PERIODONTICS - (*There is an additional \$10 per visit copayment for all non diagnostic/preventive visits*)

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.....	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.....	No Cost
D4249	Clinical crown lengthening - hard tissue	No Cost
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.....	No Cost
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.....	No Cost
D4263	Bone replacement graft - first site in quadrant.....	No Cost
D4264	Bone replacement graft - each additional site in quadrant.....	No Cost
D4270	Pedicle soft tissue graft procedure	No Cost
D4271	Free soft tissue graft procedure (including donor site surgery)	No Cost
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - <i>limited to 1 treatment in any 12 consecutive months</i>	No Cost
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 4 month period</i>	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable) - (*There is an additional \$10 per visit copayment for all non diagnostic/preventive visits*)

D5110	Complete denture - maxillary	\$212.00
D5120	Complete denture - mandibular	\$212.00
D5130	Immediate denture - maxillary.....	\$232.00
D5140	Immediate denture - mandibular.....	\$232.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).....	\$277.00

D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).....	\$277.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$277.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$277.00
D5410	Adjust complete denture - maxillary.....	No Cost
D5411	Adjust complete denture - mandibular.....	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5510	Repair broken complete denture base.....	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth).....	No Cost
D5610	Repair resin denture base.....	No Cost
D5620	Repair cast framework	No Cost
D5630	Repair or replace broken clasp.....	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture	No Cost
D5710	Rebase complete maxillary denture	No Cost
D5711	Rebase complete mandibular denture	No Cost
D5730	Reline complete maxillary denture (chairside).....	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside).....	No Cost
D5741	Reline mandibular partial denture (chairside).....	No Cost
D5750	Reline complete maxillary denture (laboratory).....	No Cost
D5751	Reline complete mandibular denture (laboratory)	No Cost
D5760	Reline maxillary partial denture (laboratory)	No Cost
D5761	Reline mandibular partial denture (laboratory).....	No Cost
D5820	Interim partial denture (maxillary) - <i>limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing</i>	No Cost
D5821	Interim partial denture (mandibular) - <i>limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing</i>	No Cost
D5850	Tissue conditioning, maxillary.....	No Cost
D5851	Tissue conditioning, mandibular.....	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge]) - (There is an additional \$10 per visit copayment for all non diagnostic/preventive visits)

D6210	Pontic - cast high noble metal	\$178.00
D6211	Pontic - cast predominantly base metal	\$150.00
D6212	Pontic - cast noble metal	\$165.00
D6240	Pontic - porcelain fused to high noble metal	\$180.00
D6241	Pontic - porcelain fused to predominantly base metal	\$150.00
D6242	Pontic - porcelain fused to noble metal.....	\$172.00
D6750	Crown - porcelain fused to high noble metal.....	\$180.00
D6751	Crown - porcelain fused to predominantly base metal	\$165.00
D6752	Crown - porcelain fused to noble metal.....	\$177.00
D6780	Crown - ¾ cast high noble metal	\$180.00
D6781	Crown - ¾ cast predominantly base metal.....	\$169.00
D6782	Crown - ¾ cast noble metal	\$177.00
D6790	Crown - full cast high noble metal.....	\$180.00
D6791	Crown - full cast predominantly base metal	\$150.00
D6792	Crown - full cast noble metal.....	\$172.00
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - <i>includes canal preparation</i>	No Cost
D6972	Prefabricated post and core in addition to fixed partial denture retainer - <i>base metal post; includes canal preparation</i>	No Cost
D6973	Core buildup for retainer, including any pins	No Cost
D6976	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	No Cost
D6977	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY - (There is an additional \$10 per visit copayment for all non diagnostic/preventive visits)

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

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No Cost

D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	No Cost
D7240	Removal of impacted tooth - completely bony	No Cost
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	No Cost
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7285	Biopsy of oral tissue - hard (bone, tooth) - <i>does not include pathology laboratory procedures</i>	No Cost
D7286	Biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.....	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue.....	No Cost
D7520	Incision and drainage of abscess - extraoral soft tissue	No Cost
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	No Cost

D8000-D8999 XI. ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> ¹	\$700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> ¹	\$700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, dependent adult children from age 19 to 21 and dependent adult children covered as full time students to age 25</i> ¹	\$1,800.00
D8660	Pre-orthodontic treatment visit - <i>not to be charged with any other consultation procedure(s)</i> ²	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers) ³	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding</i>	\$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES - (There is an additional \$10 per visit copayment for all non diagnostic/preventive visits)

D9110	Palliative (emergency) treatment of dental pain - minor procedure.....	No Cost
D9211	Regional block anesthesia.....	No Cost
D9212	Trigeminal division block anesthesia.....	No Cost
D9215	Local anesthesia.....	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.....	No Cost
D9440	Office visit - after regularly scheduled hours	No Cost
D9951	Occlusal adjustment, limited.....	No Cost
D9999	Unspecified adjunctive procedure, by report - <i>includes failed appointment - based on the Contract Dentist's filed fee and office policy.</i>	100% of Filed Fees

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees."

"Filed fees" means the Contract Dentist's or Contract Specialist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.

FOOTNOTES

- ¹ *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee." Beyond 24 months of active treatment, an additional office visit charge at the Contract Orthodontist's "filed fee" applies.*
- ² *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of \$25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*
- ³ *Includes adjustments and/or office visits up to 24 months. After 24 months, an additional office visit charge at the Contract Orthodontist's "filed fee" applies.*

SCHEDULE B

Limitations of Benefits

1. Prophylaxis is limited to one treatment each four month period (includes periodontal maintenance); Oral exams and bitewing x-rays are limited to two times per calendar year.
2. Topical application of fluoride is covered twice in a calendar year through the age of 18. Preventive therapies approved by Delta Dental are a covered benefit under certain conditions of oral health when performed at the suggested regimen for the therapy. Children through the age 18 are eligible for either topical application of fluoride or preventive therapies, but not both, as described above.
3. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five-year period from initial placement.
4. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
5. Crowns and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement.
6. Denture relines tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
7. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
8. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.
9. Full mouth x-rays are limited to one set every 36 consecutive months.
10. Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age nine and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
11. Soft tissue grafts are covered once in a three year period.
12. Accidental injury, except as noted in the Accident Injury Rider. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

13. Site specific therapies for delivery of chemotherapeutic agents are covered by the Plan as an adjunctive procedure only for specific sites that are unresponsive to conventional therapy.

"Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.

Exclusions of Benefits

1. General anesthesia and the services of a special anesthesiologist.
2. Cosmetic dental care.
3. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
4. Dental services performed in a hospital and related hospital fees.
5. Treatment of fractures and dislocations.
6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
8. Any service that is not specifically listed as a covered expense.
9. Dental expenses incurred in connection with any dental procedure started prior to Enrollee's eligibility with the DeltaCare USA program. Example: teeth prepared for crowns, root canals in progress, orthodontic treatment.
10. Congenital malformations (e.g. congenitally missing teeth, supernumerary).
11. Cysts and malignancies.
12. Dispensing of drugs not normally supplied in a dental facility.
13. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
14. Dental services received from any dental facility other than the assigned dental facility, including the services of a dental specialist unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services*.
15. Prophylactic removal of impactions (asymptomatic, nonpathological).
16. "Specialist consultations" for noncovered benefits.
17. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
18. Extractions solely for the purpose of orthodontics.

Orthodontic Limitations

The program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fee and the cost to the Enrollee for each orthodontic treatment plan are listed in Schedule A.

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Plan benefits cover 24 months of usual and customary orthodontic treatment.
3. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of \$2,300 for dependent children to age 19 and \$2,500 for adults and dependent adult children to age 21, and dependent adult children who are covered full-time students to age 25. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist. Start-up fees are included in these amounts.
4. Start-up fees cover the initial examination, diagnosis, consultation and the retention phase of treatment of up to two years maximum. This includes initial construction, placement and adjustments to retainers and office visits for a maximum period of two years.
5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of \$25.00 in addition to diagnostic record fees.
6. Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/rebandings on different teeth during the covered course of treatment is a benefit. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost.
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

8. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation.
5. Surgical procedures incidental to orthodontic treatment.
6. Myofunctional therapy.
7. Surgical procedures related to cleft palate, micrognathia or macrognathia.
8. Treatment related to temporomandibular joint disturbances.
9. Supplemental appliances not routinely used in typical comprehensive orthodontics.
10. Treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge at the Contract Orthodontist's "filed fee."
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.
14. Transfer after banding has been initiated.

"Filed fee" means the Contract Orthodontist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.

SCHEDULE C

Governing Administrative Policies

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment plans.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the Enrollee selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the two plans of treatment plus any copayment for covered procedures.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

A. PARTIAL DENTURES

A removable cast metal partial denture is considered an adequate restoration. If the Enrollee selects another course of treatment, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment, plus any copayment for the covered benefit.

If an cast metal partial denture will restore the case, the Contract Dentist will apply the difference of the cost of such procedure toward a more complicated precision appliance which the Enrollee and dentist may choose to use. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment plus any copayment for the covered benefit.

An acrylic partial denture may be considered a covered benefit in cases involving extensive periodontal disease. Enrollee shall pay the applicable copayment for an cast metal partial denture.

B. COMPLETE DENTURES

If, in the construction of a denture, the Enrollee and the Contract Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Full upper and/or lower dentures are not to exceed one each in any five-year period. The Enrollee is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either reline or repair.

C. FILLINGS AND CROWNS

Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

Porcelain or porcelain fused to metal crowns on all molars are considered optional treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

The DeltaCare USA program provides amalgam and resin restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including but not limited to cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth, or the anticipation of future fractures, are not covered benefits.

Composite resin restorations in posterior teeth are considered optional treatment. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A crown placed on a specific tooth is allowable only once in a five-year period.

A pulp cap is a benefit only on a permanent tooth with an open apex.

D. FIXED BRIDGES

A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years old or older. Such treatment will be covered if the Enrollee's oral health and general dental condition permits.

Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Replacement of an existing nonfunctional bridge is limited to once in a five-year period from initial placement and shall be covered only when the replacement duplicates the original bridge.

Fixed bridges are not a benefit for Enrollees under the age of 16. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

E. RECONSTRUCTION

The DeltaCare USA program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the DeltaCare USA program. The program will allow for complete or partial denture(s).

F. SPECIALIZED TECHNIQUES

Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

G. PREVENTIVE CONTROL PROGRAMS

Soft tissue management programs are not covered. The periodontal pocket charting, root planing/scaling/curettage, oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed copayments, if any. Irrigation, infusion, special tooth brush, etc., is considered as optional treatment. If performed, the Enrollee is responsible for the cost.

H. STAYPLATES

Stayplates in conjunction with fixed or removable appliances, are only a benefit to replace extracted anterior teeth for adults during a healing period and as anterior space maintainers for children.

I. FRENECTOMY

The frenum can be excised when the tongue has limited mobility; or has a large diastema between teeth; or when the frenum interferes with a prosthetic appliance.

J. PEDODONTIA

Pedodontic referrals must be preauthorized by Delta Dental. Benefits for dependent children through age three are covered at 100% of the agreed upon fee less any applicable copayments for covered benefits and children four years and older are at 50% of agreed upon fee less any applicable copayments for covered services.

K. TREATMENT PLANNING

The objective of this Program is to see that all Enrollees are brought to a good level of oral health and that this level of oral health is maintained. To achieve this objective takes careful treatment planning. Priorities have been established on the following basis:

1. Priority attention is given to those procedures that, if not done first, could have an immediate effect on the Enrollee's overall oral health.

2. Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the Enrollee's oral health.

Exceptions are made to this treatment planning concept based on individual circumstances.

L. SOFT TISSUE GRAFTING

Pedicle soft tissue grafting is covered on a per tooth basis and includes split thickness grafts, three months post operative care, any surgical reentry within a three year period, and any frenectomy and/or distal wedge performed in the same area on the same date. Exceptional cases will be given consideration on a by report basis. When procedure is performed as purely cosmetic dentistry, it is not a covered Benefit and is considered optional. If performed, the Enrollee must pay Contract Dentist's "filed fees" for these procedures. When procedure is performed in conjunction with other periodontal surgery, the procedure is considered to be included in the more inclusive procedure.

Free soft tissue grafting (including donor site) is covered on a per tooth basis and includes subepithelial connective tissue grafts, three months post operative care, any surgical reentry within a three year period and any frenectomy and/or distal wedge performed in the same area on the same date. Exceptional cases will be given consideration on a by report basis. When procedure is performed as purely cosmetic dentistry, it is not a Benefit and is considered optional. If performed, the Enrollee must pay the Contract Dentist's "filed fees" for these procedures. The procedure is appropriate only when not performed in conjunction with any other periodontal services in the same area. When other periodontal services are involved, this service is considered to be part of and included in the fee for the more inclusive procedure.

"Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.

Accident Injury Benefit

Delta Dental shall pay or otherwise discharge 100% of the Contract Dentist's "filed fees" not to exceed the "Prevailing Fee" as determined by Delta Dental or of Fees Actually Charged, whichever is less, less any applicable Enrollee copayments, for the following dental accident benefits:

Services described in the Schedule of Benefits and Copayments, Schedule A, and in paragraph II of this Rider, Schedule F are subject to the following maximum, limitation and exclusions when provided for conditions caused directly and independently of all other causes, by external, violent and accidental means.

I. DEFINITIONS

For the purpose of this Rider, the following additional definitions shall apply:

- A. "Attending Dentist's Statement" means the standard form used to file a claim.
- B. "Dental Accident Benefits" means those dental services which are provided under the terms of this Rider for conditions caused directly and independently of all other causes, by external, violent and accidental means.
- C. "Fee Actually Charged" means the "filed fee" for a particular dental service or procedure which a Contract Dentist reports to Delta Dental on an Attending Dentist's Statement, less any portion of such fee which is discounted, waived, rebated or which the Dentist does not in good faith attempt to collect.
- D. "Prevailing Fee" means the fee for a Single Procedure which satisfies the majority of Dentists in California, as determined by Delta Dental.
- E. "Single Procedure" means a dental procedure listed on a separate line in Schedule A and in paragraph II of this Rider, Schedule F.
- F. The term "filed fee" as used in this Rider shall have the following meaning: "Filed Fee" means the Contract Dentist's fees on file with Delta Dental.

II. DENTAL ACCIDENT BENEFITS

For the purpose of this Rider, the following additional benefits shall apply:

- A. Intra-oral grafting
- B. Reimplantation
- C. Splinting
- D. Stayplate

III. MAXIMUM

The program shall provide Dental Accident Benefits for an Eligible Person up to a maximum of \$1,600 per Enrollee per any 12 month period.

IV. LIMITATION

Dental Accident Benefits shall be limited to services provided to an Eligible Person within 180 days following the date of accident, and shall not include any services for conditions caused by an accident occurring prior to the Enrollee's eligibility date.

V. EXCLUSIONS

The following services are not Dental Accident Benefits:

- A. Services for injuries or conditions which are benefits provided to the eligible Enrollee through a medical carrier or are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.
- B. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- C. Services for restoring or stabilizing tooth structure lost from wear, or for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion. Such services include but are not limited to: equilibration and periodontal splinting.
- D. Prosthodontic services or any Single Procedure started prior to the date the Enrollee became eligible for such services under this Contract.
- E. Prescribed drugs, pre-medication or analgesia.
- F. Experimental procedures.
- G. Prophylaxis.
- H. All hospital costs and any additional fees charged by the Dentist for hospital treatment.
- I. Charges for general anesthesia.
- J. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
- K. Implants (materials implanted into or on bone or soft tissue), the removal of implants or procedures related to the placement or removal of implants.
- L. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
- M. Replacement of existing restorations due to carious lesions.
- N. Orthodontic services (treatment of malalignment of teeth and/or jaws).

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Administered by:

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Cerritos, CA 90703-8579