

DELTA PREMIER
Managed Fee-for-Service Program

For
Employees
Of

SISKIYOU
JOINT
COMMUNITY
COLLEGE
DISTRICT

Group
Number
6709-0001

Combined
Evidence
of
Coverage
and
Disclosure
Form

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 program. 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 CHOOSING YOUR DENTIST section). You have a right to review it prior to your enrollment.

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

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

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

DELTA DENTAL PLAN OF CALIFORNIA

P.O. Box 7736
San Francisco, California 94120

For claims, eligibility and benefits inquiries, or additional information, call Delta’s Customer and Member Service Department toll-free at:
1-888-335-8227.

Or contact us on the Internet at:

e-mail: cms@delta.org
web site: www.deltadentalca.org

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

TABLE OF CONTENTS

DEFINITIONS.....	3	ORGAN AND TISSUE DONATION.....	12
WHO IS COVERED?	3	COMPLAINT PROCEDURE, CLAIMS APPEAL AND ARBITRATION.....	12
WHO ARE YOUR ELIGIBLE DEPENDENTS?	4	IF YOU HAVE ADDITIONAL COVERAGE.....	13
ENROLLING YOUR DEPENDENTS.....	4	OPTIONAL CONTINUATION OF COVERAGE.....	13
WHEN YOU ARE NO LONGER COVERED	4		
CANCELING THIS PROGRAM	5		
YOUR BENEFITS.....	5		
LIMITATIONS	7		
EXCLUSIONS/SERVICES WE DO NOT COVER	8		
COVERED FEES	9		
CHOOSING YOUR DENTIST	9		
CONTINUITY OF CARE	10		
PUBLIC POLICY PARTICIPATION BY ENROLLEES	10		
SAVING MONEY ON YOUR DENTAL BILLS	10		
YOUR FIRST APPOINTMENT	10		
PREDETERMINATIONS.....	10		
PAYMENT.....	11		
IF YOU HAVE QUESTIONS ABOUT SERVICES FROM A DELTA DENTIST.....	11		
SECOND OPINIONS.....	12		

DEFINITIONS

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

Attending Dentist's Statement - a form used by your dentist to request payment for dental treatment or predetermination for proposed dental treatment.

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 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 will apply Benefit payments, according to the Contract.

Delta Dentist - a dentist who has a signed agreement with Delta. These dentists have filed their Usual fees, which have been accepted by Delta as Customary and Reasonable. They agree to charge Delta patients these accepted fees.

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 program starts.

Enrollee – A Primary Enrollee or Dependent enrolled to receive Benefits or a person who chooses to pay for OPTIONAL CONTINUATION OF COVERAGE.

Maximum - the greatest dollar amount Delta will pay for covered procedures in any calendar year.

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 Delta has assigned a separate procedure number; for example, a three-surface amalgam restoration of one permanent tooth (procedure 02160) or a complete upper denture, including adjustments for a six-month period following installation (procedure 05110).

Usual, Customary and Reasonable (UCR) –

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

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

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

WHO IS COVERED?

All regular full-time employees are required to enroll and will become eligible to receive Benefits on the first day of the month following the month in which their employment or service begins.

New Dependents should be enrolled as soon as they become Dependents, and they will then immediately be covered for dental Benefits.

Primary Enrollees on military reserve will be allowed one-year leave of absence. Upon return from military reserve, the Primary Enrollee will be fully reinstated. Military reservist who previously had coverage will return to their previous attained level of coverage. Dependents of employees on active duty will be allowed to continue coverage under this Program.

Primary Enrollees returning from an unpaid leave of absence, shall be reinstated on the first day of paid service or the first day on return from leave of absence.

WHO ARE YOUR ELIGIBLE DEPENDENTS?

- Your legal spouse;
- Your unmarried dependent children until their 25th birthday;
- An unmarried dependent child aged 25 or older who is incapable of self-support because of a physical or mental handicap that occurred before he or she turned 25, if the child is mostly dependent on you for support. Proof of this handicap must be given to Delta or your employer within 31 days, if it is requested. Proof will not be required more than once a year after the child has reached age 27.

“Dependent children” also means stepchildren, adopted children, children placed for adoption and foster children, provided that they are dependent upon you for support and maintenance.

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, unless you qualify for and pay for OPTIONAL CONTINUATION OF COVERAGE. Your Dependents’ coverage ends when yours does, or as soon as they are no longer Dependents,

unless they choose to pay for OPTIONAL CONTINUATION OF COVERAGE.

2. When the Contract between Delta and your employer is discontinued or canceled, your coverage ends immediately.
3. When you are on strike, layoff or leave of absence, Delta does not cover any dental services received by you or your Dependents.

The following options may be offered if your eligibility ends:

1. Transfer to another district

If you and your Dependents transfer to another School District that has the same Delta program, your percentage share of the bill for dental services will remain the same, as long as there is no break (month(s) in which you are ineligible) in coverage during the transition.

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.

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 Reemployment Rights Act of 1994

You can continue coverage for up to 18 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 dues necessary, which may include administrative cost, 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 make 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 PROGRAM

Delta may cancel this program only on an anniversary date (period after the program first takes effect or at the end of each renewal period thereafter), or any time your group does not make payment as required by the Contract.

If you believe that this program has been terminated or not renewed due to your health status or

requirements for health care services (or that of your Dependents), you may request a review by the California Director of the Department of Managed Health Care.

If the Contract is terminated for any cause, Delta 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 program is canceled, you and your Dependents have no right to renewal or reinstatement of your Benefits.

YOUR BENEFITS

Maximums

The Maximum amount paid by Delta for each Enrollee each calendar year for Diagnostic, Preventive, Basic, Restorative and Prosthodontic Benefits is \$1,000.

The lifetime Maximum amount paid by Delta for an Enrollee for Orthodontic Benefits is \$1,000.

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

Your Benefits

Your program 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.

Delta will pay 70% of the Covered Fees for the Diagnostic, Preventive, Basic, Crown 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 program, 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 percentage for Prosthodontic, Orthodontic and Dental Accident Benefits does not change each year your visit your dentist.

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

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

I. DIAGNOSTIC AND PREVENTIVE BENEFITS – 70-100%

Diagnostic – oral examinations; z-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%

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 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 schedule hours; therapeutic drug injection; treatment of post-surgical complications (unusual circumstances); limited occlusal adjustment

III. CROWNS, JACKETS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS – 70-100%

Crowns, Jackets, 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%

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

V. ORTHODONTIC BENEFITS – 50%

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

VI. DENTAL ACCIDENT BENEFITS–100%

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

LIMITATIONS

1. An oral examination by a Delta Dentist is a Benefit only if the Dentist has an accepted fee on file with us for this procedure.
2. Oral examinations are Benefits only twice in a calendar year while you are eligible under any Delta program.
3. Full-mouth x-rays are Benefits only once in a three-year period while you are eligible under any Delta program.
4. Bitewing x-rays are provided on request by the dentist, but no more than twice in a calendar year while you are eligible under any Delta program.
5. Only the first two cleanings, or Single Procedures which include cleaning, or combination thereof, provided to a patient in a calendar year are Benefits while you are eligible under any Delta program.
6. 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.
7. Crowns, Jackets, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are eligible under any Delta program, unless Delta 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.
8. Prosthodontic appliances are Benefits only once every five years, while you are eligible under any Delta program, unless Delta determines that there has been such an extensive loss of remaining teeth or a change in supporting tissue that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta program will be made if it is unsatisfactory and cannot be made satisfactory.
9. Delta will pay the above percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance. This fee allowance is the fee that would satisfy the majority of Delta's Dentists. A standard partial or complete denture is one made from accepted materials and by conventional methods. The maximum fee allowance is revised periodically, as dental fees change. If your dentist's accepted fee on file with Delta for a partial or complete denture is higher than this maximum allowance, you must pay the portion of his or her fee that exceeds Delta's allowance in addition to your portion of the allowance.
10. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your program. However, if implants are provided along with a covered prosthodontic appliance, Delta will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If Delta makes such an allowance, we will not pay for any replacement for five years following the completion of the service.
11. 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.
12. Delta's 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.

13. 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.
14. 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.
15. If an Enrollee selects 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 will pay the applicable percentage of the lesser fee for the customary or standard treatment and the patient is responsible for the remainder of the dentist's fee.

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

EXCLUSIONS/SERVICES WE DO NOT COVER

Delta 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 does not provide benefits for:

1. Services for injuries covered by Workers' compensation or Employer's Liability Laws.
2. Services which are provided to the Enrollee by any Federal or State Governmental Agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.
3. 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.
4. 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.
5. Any Single Procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this program.
6. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.
7. Experimental procedures.
8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
9. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.
10. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").
11. Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants or any treatment in conjunction with implants, except as provided under LIMITATIONS.
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 restoring active tooth decay or fracture of the restoration.
14. Intravenous sedation, occlusal guards and complete occlusal adjustment.
15. Charge for replacement or repair of an orthodontic appliance paid in part or in full by this program.

COVERED FEES

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

A list of Delta Dentists (see DEFINITIONS) is available in a directory at your group benefits office, or by calling 1-800-427-3237.

Payment to a Delta 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.

Payment to a dentist outside of California who agrees to be bound by Delta’s rules in the administration of the program will be based on the applicable percentage of the lesser of the Fee Actually Charged or the Customary Fee for corresponding services for Delta Dentists in California.

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

CHOOSING YOUR DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF

PROVIDERS HEALTH CARE MAY BE OBTAINED.

More than 18,000 dentists in active practice in California are Delta Dentists. You are free to choose any dentist for treatment, but it is to your advantage to choose a Delta Dentist. This is because his or her fees are approved in advance by Delta. Delta Dentists have treatment forms on hand and will complete and submit the forms to Delta free of charge.

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

A list of Delta Dentists can be obtained by calling 1-800-427-3237. This list will identify those dentists who can provide care for individuals who have mobility impairments or have special health care needs. You can obtain specific information about Delta Dentists by using our web site – www.deltadentalca.org or calling the Delta Customer and Member Service Department at the number shown on page 1. A printed list of the Delta Dentists in your area is also available by calling 1-800-427-3237.

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 which is listed in the local telephone directory.

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

Delta shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta 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, or to you. Delta

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

If you are undergoing a course of treatment and your dentist no longer is a Delta Dentist, you may continue to receive treatment from that dentist.

PUBLIC POLICY PARTICIPATION BY ENROLLEES

Delta's Board of Directors includes Enrollees who participate in establishing Delta's public policy regarding Enrollees through periodic review of Delta's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta's public policy in writing to: Delta Dental Plan of California, Customer and Member Service Department, P.O. Box 7736, San Francisco, CA 94120.

SAVING MONEY ON YOUR DENTAL BILLS

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

1. Comparing the fees of different dentist;
2. Using a Delta Dentist;
3. Having your dentist obtain predetermination from Delta for any treatment over \$300;
4. Visiting your dentist regularly for checkups;
5. Following your dentist's advice about regular brushing and flossing;
6. Avoiding putting off treatment until you have a major problem; and
7. By learning the facts about overbilling. Under this program, you must pay the dentist your

copayment 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 program and may do more work than you need, thereby increasing program 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 group number (on the front of this booklet);
2. The employer's name;
3. Primary Enrollee's social security number (which must also be used by Dependents);
4. Primary Enrollee's date of birth;
5. Any other dental coverage you may have.

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. If is an estimate of the amount Delta will pay if you are eligible and meet all the requirements of your program at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send an Attending Dentist's Statement to us listing the proposed treatment. Delta will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go

ahead with the treatment plan, your dentist returns the statement to us for payment when treatment has been completed.

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

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.

PAYMENT

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

Delta does not pay Delta 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 Dentists, you may call Delta's Customer and Member Service Department for more information.

Payment for any Single Procedure which is a Covered Service will only be made upon completion of that procedure. Delta 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 program.

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

Delta may deny payment of any Attending Dentist's Statement for services submitted more than six months after the date the services were provided. If a claim is denied due to a Delta 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 (unless you failed to advise the dentist of your eligibility at the time of treatment).

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

IF YOU HAVE QUESTIONS ABOUT SERVICES FROM A DELTA DENTIST

If you have questions about the services you receive from a Delta Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call our Quality Review Department at 1-888-335-8227. If appropriate, Delta 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 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 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 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 will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. Delta 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 to perform the clinical examination. When Delta authorizes a second opinion through a Regional consultant, we will pay for all charges.

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

This is only a summary of Delta's policy on second opinions. A copy of Delta's formal policy is available from Delta's Customer and Member Service Department upon request.

ORGAN AND TISSUE DONATION

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

identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

COMPLAINT PROCEDURE, CLAIMS APPEAL AND ARBITRATION

If you have any question about the services you receive from a Delta Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call our Quality Review Department at 1-888-335-8227.

We will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for denial. If you have a question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures and operations of Delta, or the quality of dental services performed by a Delta Dentist, you may contact us at the telephone number shown on page 1. You have 60 days after you receive notice of denial to appeal. If you write, you must include the name of the patient, the group name and number, the Primary Enrollee's name and social security number or identification number and your telephone number on all correspondence. You should also include a copy of the treatment form, Notice of Payment and any other relevant information. Clearly explain your complaint and send it to us at the address shown on page 1.

We will review your complaint and will resolve the matter within 30 days of receipt or inform you of the pending status of the complaint if more information or time is needed to resolve the matter. We may need more time if your complaint is referred to a dental consultant or to a peer review committee of the local dental society. If a referral is necessary, a reply will be sent to you in no more than 120 days after we receive your complaint. We will respond within three days of receipt to complaints involving severe pain and imminent and serious threat to a patient's health.

The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free number **1-800-**

400-0815 to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)** to contact the department. The department's Internet web site <http://www.dmoHELP.ca.gov> has complaint forms and instructions online. If you have a grievance against the plan, you should first telephone the plans at **1-888-335-8227B** and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Disputes relating to your plan, including claim denials, may be settled by arbitration if they cannot be settled by this complaint process. Arbitration will follow the Commercial Rules of the American Arbitration Association (AAA). You can begin this process by giving written notice to each party (for example, Delta and your dentist) with whom you want to arbitrate, explaining the dispute and the amount involved, if any, and the solution you wish. You must then file two copies of the notice with the Association's regional office in Los Angeles or San Francisco, along with the fee required by the Association.

In the event of extreme hardship on the part of an Enrollee or subscriber, and upon an application for relief presented to the AAA, Delta shall assume all or a portion of the arbitration fees and expenses as determined by the AAA in accordance with procedures established and administered by the AAA.

IF YOU HAVE ADDITIONAL COVERAGE

It is to your advantage to let your dentist and Delta know if you have dental coverage in addition to the Delta program. Most dental carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs – sometimes paying 100% of your dental bill. For example, you might have some fillings which 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 programs under which you have dental coverage and have him or her complete the dual coverage and have him or her complete the dual coverage portion of the Attending Dentist's Statement, so that you will receive all benefits to which you are entitled. For further information, contact the Delta Customer and Member Service Department at the number in the USING THIS BOOKLET section.

OPTIONAL CONTINUATION OF COVERAGE

The federal consolidated Omnibus Budget Reconciliation Act (COBRA) requires 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 or your Dependents may be entitled to continue coverage under this program, at the Qualified Beneficiary's expense, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section are shown below.

Qualified Beneficiary means:

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

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

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

You means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

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 the employer within 30 days of any such determination.

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

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

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

ELECTION OF CONTINUED COVERAGE

Your employer will provide a Qualified Beneficiary with the necessary benefits information, monthly Dues charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give the 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 the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial Dues to the employer, which includes the Dues for each month since the loss of coverage. Failure to pay the required Dues within 45 days will result in the loss of the right to continue coverage, any Dues 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 will change as well. Dues will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

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

1. the allowable number of consecutive months of continued coverage is reached;
2. failure to pay the required Dues in a timely manner;
3. the employer ceases to provide any group dental plan to its employees;
4. the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or Dependent) which does not contain or apply any exclusion or limitation with respect to any

pre-existing condition of such a person, if that pre-existing condition is covered under this program; or

5. entitlement to Medicare.

Once continued coverage ends, it cannot be reinstated.