UNIVERSITY OF CALIFORNIA

Employees, Retirees, and Their Dependents

EVIDENCE OF COVERAGE AND DISCLOSURE STATEMENT

January 1, 2005

Group Numbers: 3999 & 4999

Provided by:

Delta Dental of California
100 First Street
San Francisco, CA 94105
1-800-777-5854

AN EVIDENCE OF COVERAGE OF THE DENTAL PROGRAM FOR ELIGIBLE EMPLOYEES AND RETIREES OF THE UNIVERSITY OF CALIFORNIA

This booklet is a Summary of the Dental Program ("Program") and has been prepared for participants who are employees of and retirees of the University of California.

This Program has been established and is maintained and administered in accordance with the provisions of group Dental **Contract No. 3999** issued by Delta Dental of California ("Delta") and the University of California Group Insurance Regulations.

DELTA DENTAL OF CALIFORNIA
P.O. Box 997330
Sacramento, California 95899-7330
1 (800) 777-5854

Or contact us on the Internet at:

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

IMPORTANT

This booklet is subject to the provisions of the Dental Contract and the University of California Group Insurance Regulations and cannot modify or affect these Documents in any way, nor shall you accrue any rights because of any statement in or omission from this booklet. Some provisions of this Program may not apply to employees in certain exclusively represented bargaining units.

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 AND THE UNIVERSITY OF CALIFORNIA GROUP INSURANCE REGULATIONS 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. PLEASE READ THIS EOC CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED “HOW TO USE YOUR PROGRAM”.

A STATEMENT DESCRIBING DELTA’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 FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

The telephone number at which you may obtain information about benefits is 1-800-777-5854.

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University of California Eligibility, Enrollment and Plan Administration Provisions
January 1, 2005

The information in this section applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document. The University establishes its own health and welfare plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations"). Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan.

Subscriber

Employee: You are eligible if you have an appointment type which is eligible for benefits, and are a member of a UC-sponsored retirement plan. Generally, there are two ways to qualify for UCRP membership: 1) you are appointed to work at least 50% time for a year or more or 2) you worked 1,000 hours* in a rolling twelve-month period in a position eligible for UCRP membership. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment.

* Lecturers – see your Benefits Office for eligibility.

****** For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked by you in the preceding twelve (12) month period.

(a) A month with zero regular paid hours which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours which occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment the following will apply.

(a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.

(b) If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.

Retiree (including Survivor Retiree):

Retiree - A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan. For UC health & welfare purposes a Retiree must also satisfy graduated eligibility rules, if applicable, and meet other requirements set forth in the University of California Group Insurance Regulations.

Survivor Retiree - A deceased Employee's or Retiree's family member receiving monthly benefits from a University-sponsored defined benefit plan. For UC health & welfare purposes, the Retiree must also have satisfied graduated eligibility rules, if applicable, and met other requirements set forth in the University of California Group Insurance Regulations.

You may continue University dental plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a Survivor Retiree when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree dental eligibility including graduated eligibility, if applicable;
(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor Retiree); and
(c) you elect to continue dental coverage at the time of retirement.

For more information about continuing dental plan coverage into retirement, including service credit and graduated eligibility requirements, see the UC Retirement Handbook or contact the University's Customer Service Center.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return or other official documentation. In addition, you will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

Spouse: Your legal spouse. (Note: if you are a Survivor Retiree, you may not enroll your legal spouse.)

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group dental plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored health plan are eligible for continued coverage under any other University-sponsored dental plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group dental coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

New Mexico Residents Only – Due to a New Mexico state law effective January 1, 2004, certain dependent children of UC employees and Retirees may be eligible for dental plan coverage until age 25. See the UC Group Insurance Eligibility Factsheet or your local Benefits Office for details.

Other Eligible Dependents (Family Members):

You may enroll a domestic partner (and the domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations.

Effective January 1, 2005, the University will recognize an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and the domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor Retiree or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored dental plans.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan you are enrolled in.

(a) For a spouse, on the date of marriage. Survivor Retirees may not add Spouses to their coverage.

(b) For a natural child, on the child's date of birth.

(c) For an adopted child, the earlier of:
(i) the date you or your Spouse has the legal right to control the child's health care, or
(ii) the date the child is placed in your physical custody.
If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group dental plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

At Other Times

You and your eligible Family Members may also enroll during a group open enrollment period established by the University. COBRA enrollees may also enroll their Family Members during a group open enrollment period.

If you have two or more Family Members enrolled in the Plan, you may add a newly eligible Family Member at any time. See "Effective Date".

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor Retiree, you may not enroll your legal spouse or domestic partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the child becomes eligible, or
(b) a maximum of 60 days prior to the date your Family Member is enrolled (either by receipt of his/her enrollment form by the local Accounting or Benefits Office or by electronic enrollment.

Change in Coverage

In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Family Member to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor Retiree and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Misuse

Coverage for you and your Family Members may be terminated for misuse of the Plan, including but not limited to such actions as fraud or deception in the use of the services of the Plan, knowingly permitting such fraud or deception by another, or threats or abusive behavior towards Plan providers or representatives. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who misuses the Plan will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 12 months. If a Subscriber misuses the Plan, the Subscriber and any Family Members will be deenrolled for 12 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UC Benefits website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

PLAN ADMINISTRATION

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the insurance contract. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Delta Dental of California at the following address and phone number:

Delta Dental of California
Delta Tower at 100 First Street
P.O. Box 997330
Sacramento, CA 95899-7330
(800) 777-5854
(415) 972-8300

Group Contract Number

The Group Contract Number for this Plan is: 3999

Type of Plan

This Plan is a health and welfare plan that provides group dental care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, and what portion of the premiums you and the University will pay. The portion of the premiums that the University pays is determined by UC and may change or stop altogether; and may be affected by the state of California's annual budget appropriation.

Financial Arrangements
The benefits under the Plan are provided by Delta Dental of California under a Group Dental Contract. The cost of the premiums is currently paid entirely by the University of California.

Agent for Serving of Legal Process
Legal process may be served on Delta Dental of California, at the address listed above.

Your Rights under the Plan
As a participant in a University of California dental plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Insurance contract, at a time and location mutually convenient to the participant and the Plan Administrator.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan
To file a claim or to appeal a denied claim, refer to page 17 of this document.

Nondiscrimination Statement
In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Executive Director Sheila O'Rourke, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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 (ADS) - 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.

By Report - documentation submitted to Delta by the Dentist demonstrating the clinical need for the procedure.

Contract or Group Dental Contract - the written agreement between Delta and the Employer 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.

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

Delta Dentist - a Dentist who has signed an agreement with Delta or a Participating Plan, agreeing to provide services under the terms and conditions established by Delta or the Participating Plan. Dentist – a duly licensed Dentist legally entitled to practice dentistry when and where services are provided.

DeltaPreferred Option Dentist - a Delta Dentist who meets the criteria for the DeltaPreferred Option program and has made a special agreement with Delta to participate in this program, or in California a Delta Dentist who specializes in oral surgery, endodontia and periodontia.

Dependent - a Primary Enrollee's Dependent or an Eligible Retiree's Dependent who is eligible to be enrolled for Benefits in accordance with the conditions of eligibility outlined in this booklet.

Effective Date - the date this program starts.

Eligible Retiree - any Retiree who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this brochure.

Employer - The Regents of the University of California for whose employees and Retirees dental Benefits are provided.

Enrollee - a Primary Enrollee, Eligible Retiree or Dependent enrolled to receive Benefits or a person who chooses to pay for OPTIONAL CONTINUATION OF COVERAGE.

Fee Actually Charged - the fee for a particular dental procedure submitted on an ADS, less any part of that fee which is discounted, waived, or rebated, or which the Dentist does not use good faith efforts to collect.

Maximum - the greatest dollar amount Delta will pay for covered procedures in any calendar year (and during the Enrollees lifetime for Orthodontic Benefits and TMJ Benefits.)

Non-routine exam - an examination for an emergency (for example, an injury or infection) or an examination for a specific dental problem (for example, a toothache or an exam to evaluate the need for oral surgery).

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

Patient Copayment – the portion of the Dentist's fee or allowances which is the Enrollee's responsibility.

Premiums – the amounts payable to Delta used to provide coverage to you and your dependents.

Prevailing Fee– an allowance determined by Delta and/or a Participating Plan for services provided by a dentist who is not a Delta Dentist.

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

Routine exam - an initial exam with a new dentist or a periodic exam with your current dentist to generally assess your dental health.

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

HOW TO USE YOUR PROGRAM

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

Delta does not guarantee the availability of any particular dentist.

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 choose a DeltaPreferred Option Dentist, you will receive all of the advantages of going to a Delta Dentist, and you may have less out-of-pocket expenses for certain services.

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.

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 should be submitted to Delta at the address listed in this brochure within six months. It is your responsibility to give Delta the required information necessary to evaluate your claim for dental benefits.

A list of DeltaPreferred Option Dentists and Delta Dentists can be obtained by calling 1-800-427-3237 or visit our website. 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 DeltaPreferred Option Dentists and Delta Dentists by using our web site – www.deltadentalca.org or by calling the Delta Customer Service department.

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

You should receive timely notification from Delta about whether Benefits will be received under the plan. If Delta needs more time to make a determination, you will be notified within 90 days and told why, **once you have provided all required information.** No more than an additional 90 days will be required to process the claim.

Many dentists are familiar with Delta Dental Care Programs and have Delta Attending Dentist's Statements (Delta Form 105). If not, the Dentist may contact:

DELTA DENTAL OF CALIFORNIA
P.O. Box 997330
Sacramento, CA 95899-7330
Tel. No. (415) 972-8300

To obtain Benefits, your Dentist should submit a claim form to the Delta San Francisco office.

Services 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.

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, it will pay for all charges.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examination may be submitted to Delta 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 Service department upon request.

GRIEVANCE PROCEDURE AND CLAIMS APPEAL

If an Enrollee has any questions about the services received from a Delta Dentist, Delta recommends that he or she first discuss the matter with the Dentist. If he or she continues to have concerns, the Enrollee may call or write Delta. Delta will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. Any questions of ineligibility should first be handled directly between the Enrollee and the group. If an Enrollee has any question or complaint regarding 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, he or she may call Delta toll-free at 1-800-777-5854, contact Delta on the Internet through e-mail: cms@delta.org or through the web site: www.deltadentalca.org or write Delta at P. O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

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

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

Delta will provide the Enrollee a written acknowledgement within 5 days of receipt of the request for review. Delta will make a written decision within 30 days of receipt, or inform the Enrollee of the pending status if more information or time is needed to resolve the matter. Delta will respond, within 3 days of receipt, to complaints involving severe pain and imminent and serious threat to a patient's health. An Enrollee may file a complaint with the Department of Managed Health Care after he or she has completed Delta's grievance procedure or after he or she has been involved in Delta's grievance procedure for 30 days. An Enrollee may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If the enrollee has a grievance against the health plan, they should first telephone the plan at **(1-800-777-5854)** and use the 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 an enrollee. If the enrollee needs 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, the enrollee may call the Department for assistance. Enrollees may also be eligible for an Independent Medical Review (IMR)**.** If the enrollee is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

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

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 of California, Customer Service department, P. O. Box 997330, Sacramento, CA 95899-7330.

COORDINATION OF BENEFITS (DUAL COVERAGE)

If a group insurance policy or any other group health Benefits program, including another Delta program, entitles a person to receive or be reimbursed for the cost of dental services, which are also Benefits under this program, and if this program is "primary" under the rules described below, Delta will provide Benefits as if the other program did not exist. If the other program is "primary" under these rules, then Delta will provide Benefits under this program only to the extent that the other program does not fully provide the dental services.

If the other program mainly covers services or expenses other than dental care, this program is "primary". Otherwise, Delta will use the following rules to determine which program is "primary":

(a) The program which covers the person as other than a Dependent is primary over the program which covers the person as a Dependent, with the following exception:

If the person is also a Medicare Beneficiary and Medicare is:

(i) secondary to the program covering the person as a Dependent; and

(ii) primary to the program covering the person as other than a Dependent (for example, a retired employee),

then the Benefits of the program covering the person as a Dependent are determined before the Benefits of the program covering the person as other than a Dependent.

(b) The program which covers a child as a Dependent of a parent whose birthday occurs earlier in a calendar year is primary over the program which covers a child as a Dependent of a parent whose birthday occurs later in a calendar year (except for a dependent child whose parents are separated or divorced as described in (c) below).

(c) In the case of a dependent child whose parents are legally separated or divorced:

(i) If the parent with custody has not remarried, the program which covers the child as a Dependent of the parent with custody is primary over the program which covers the child as a Dependent of the parent without custody.

(ii) If the parent with custody has remarried, the program which covers the child as a Dependent of the parent with custody is primary over the program which covers the child as a Dependent of the step-parent, and the program which covers the child as a Dependent of the step-parent is primary over the policy or program which covers the child as a Dependent of the parent without custody.

(iii) If there is a court decree that establishes financial responsibility for dental services which are Benefits under this program, then notwithstanding (i) and (ii), the program which covers the child as a Dependent of the parent with such financial responsibility is primary over any other program which covers the child.

The Benefits of a program covering a laid-off or retired employee (or Dependent of such person) shall be determined after the Benefits of any other program covering such person as an employee.

If a person whose coverage is provided under federal or state law requiring continuation is covered under more than one program, Benefits order shall be determined as follows:

(a) The Benefits of the program covering the person as an employee or Dependent shall be primary.

(b) The Benefits under continuation coverage shall be secondary.

If the primary program cannot be determined by the rules described in this Article 6, the program which has covered the person longer shall be primary.

An Enrollee will provide Delta with any information about the person that is needed to administer this Article, and Delta may release any information to or obtain any information from any insurance company or other organization in order to coordinate the Benefits of an Enrollee. Delta in its sole discretion will determine whether any reimbursement is warranted to
an insurance company or other organization under this provision, and it is agreed that any such reimbursement paid by Delta will be Benefits under this Contract. Delta has the right to recover the value of any Benefits provided by Delta which exceed its obligations under the terms of this provision from a Delta Dentist, Enrollee, insurance company or other organization, as Delta chooses.

CANCELLATION AND RENEWAL

This Dental Care Program may be canceled by Delta only on an anniversary date, or at any time if the Employer fails to make applicable payments as required by the Contract, or upon Employer's failure to furnish Delta a list of all individuals enrolled as specified in the Contract, or refusal to permit the inspection of Employer's records as specified in the Contract. Upon cancellation of the Program, individual employees and their Dependents of the group have no right to renewal or reinstatement.

This Dental Care Program may be canceled by the Employer at any time upon 60 days written notice to Delta.

BENEFITS PROVIDED BY THE PROGRAM

Your program covers the following services when they are provided by a licensed Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. See also **Limitations and Exclusions.**

Although the levels (i.e. percentages) of Benefits are the same no matter what dentist you choose, your out-of-pocket expenses may differ depending upon whether you select a DeltaPreferred Option Dentist. When receiving treatment from a non-DeltaPreferred Option Dentist, you will have potentially greater out-of-pocket expenses. Please refer to the section entitled Covered Fees for additional details.

I. PREVENTIVE BENEFITS – 100% of the DeltaPreferred Option Dentist or Delta Dentist fees
100% of the Delta allowance for non-Delta Dentists

Preventive – prophylaxis (cleaning); fluoride treatment; space maintainers; oral examinations; x-rays; diagnostic casts; palliative (emergency) treatment of dental pain only

OTHER PREVENTIVE BENEFITS – 75% of the DeltaPreferred Option Dentist or Delta Dentist fees
75% of the Delta allowance for non-Delta Dentists

Pit and fissure sealants – see limitation (h).

II. BASIC BENEFITS – 75% of the DeltaPreferred Option Dentist or Delta Dentist fees
75% of the Delta allowance for non-Delta Dentists

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

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

Endodontic - treatment of the tooth pulp, including root canal therapy.

Periodontic - treatment of gums and bones that support the teeth.

General Anesthesia – for covered Oral Surgery services administered by a licensed Dentist and for disabled patients whose disability necessitates anesthesia in order for the dentist to provide treatment.

Prosthodontic appliance repair

III. CROWNS, JACKETS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS – 50% of the DeltaPreferred Option Dentist or Delta Dentist fees 50% of the Delta allowance for non-Delta Dentists

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% of the DeltaPreferred Option Dentist or Delta Dentist fees 50% of the Delta allowance for non-Delta Dentists

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

V. ORTHODONTIC BENEFITS – 50% of the DeltaPreferred Option Dentist or Delta Dentist fees 50% of the Delta allowance for non-Delta Dentists

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

VI. TEMPOROMANDIBULAR JOINT (TMJ) BENEFITS – 50% of the DeltaPreferred Option Dentist or Delta Dentist fees 50% of the Delta allowance for non-Delta Dentists

Covered procedures for the treatment of TMJ dysfunction are limited to:

- occlusal guards – for treatment of grinding, crunching or bruxing teeth
- occlusal orthotic devices

Since these are the only covered procedures for this specific condition, it is strongly suggested you obtain a predetermination of treatment from Delta to determine the patient's share.

LIMITATIONS AND EXCLUSIONS

LIMITATIONS

a) Routine oral examinations shall not be provided more than once in a calendar year while the patient is an Enrollee under any Delta Program.

b) Non-routine oral examinations shall not be provided more than twice in a calendar year while the patient is an Eligible Person under any Delta program.

c) Fluoride treatments include prophylaxis and are limited to children through age 13.

d) Unless special need is shown, full-mouth x-rays are a Benefit once in a five-year period while you are eligible under any Delta program.

e) Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults age 18 and over, while you are eligible under any Delta program.

f) Emergency palliative treatment is limited to three visits per calendar year for treatment of the same problem.

g) Space maintainers are limited to children through age 12 and only once every five years while you are eligible under any Delta program.

h) Pit and fissure sealant Benefits include the application of sealants only to permanent first molars through age 9 and second molars through age 15 if they are without caries (decay), or restoration on the occlusal surface.

i) Periodontal procedures which include prophylaxis are limited under Limitation p).

j) Periodontal root planing (scaling and root planing to include removal of supra and subgingival calculus as one procedure) is limited to one quadrant in a 24-month period.

k) 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 by the dentist, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

l) Prosthodontic appliances (including but not limited to, fixed bridges and partial or complete dentures) 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 tissues 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.

m) Delta will pay its percentage of the dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture. A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.

n) Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) or the removal of implants 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.

o) Benefits under this program will include only the first two prophylaxes, or Single Procedure which includes prophylaxes, or combination thereof, provided to a patient in a calendar year while he or she is an Enrollee under any Delta program. Additional cleanings may be allowed By Report if documentation demonstrates that the procedure is clinically necessary.

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

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

q) 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.

r) Delta's orthodontics payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed, or the termination date of the Contract, whichever shall occur first.

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

t) Dental services associated with treatment of TMJ dysfunction which are not listed as TMJ Benefits may be covered under Preventive or Basic Benefits.

u) Charges for replacement of lost, missing or stolen devices are not covered.

v) Occlusal guards or occlusal orthotic devices will be repaired or replaced only after three years have elapsed following any prior provision of such appliances under this program, except when Delta determines that there is such extensive change in the patient's dental condition (such as loss of a tooth or teeth) that the existing appliance cannot be made functional.

w) Replacement of an occlusal guard or occlusal orthotic device not provided under a Delta contract will be made only if it is unsatisfactory and cannot be made functional.

x) Services for bruxism (grinding of teeth) unrelated to TMJ dysfunction are not covered.

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, services which are provided by any federal or state government agency, or are provided without cost by any municipality, county or other political subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.

2. 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.

3. 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.

4. Any Single Procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this program.

5. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.

6. Experimental procedures.

7. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

8. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures and for disabled enrollees whose disability necessitates anesthesia in order for the dentist to provide treatment.

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

10. Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants, except as provided under Limitations.

11. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues, except those procedures listed in the Benefits Provided by the Program.

12. Replacement of existing restoration for purposes other than active tooth decay. Replacement will not be made within two years, if done by the same dentist or by a dentist at the same dental office, unless due to external violent means, recurrent caries or radiation therapy.

13. Intravenous sedation.

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

15. Surgical procedures for correction of malalignment of teeth and/or jaws.

16. Services provided by a relative.

17. Gingival curettage.

18. Injection of antibiotic drugs.

AMOUNT OF BENEFITS PAYABLE

After you have satisfied the deductible requirements stated below, the program provides payment of the indicated percentage of the remaining covered fees up to the maximum of $1,500 for each Enrollee in each calendar year for the following Benefits:

Preventive Benefits.....100%
Other Preventive Benefits 75%
(Pit and Fissure Sealants)
Basic Benefits 75%
(Restorative, Oral Surgery, Endodontics, Periodontics, General anesthesia, Prosthetic Appliance Repair)

Crowns, Jackets, Inlays, Onlays, and Cast Restoration Benefits 50%
Prosthodontic Benefits 50%

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

For a more complete description of Benefits, refer to Benefits Provided by the Program. The amount of Benefits payable is subject to Limitations and Exclusions.

Deductible: You will be responsible for the first $50.00 of covered fees for each eligible member of your family in each calendar year. This Deductible does not apply to Preventive Benefits (including Pit and Fissure Sealant Benefits) or Orthodontic Benefits.

TMJ BENEFITS

The program provides payment of 50% of covered fees for occlusal guards and occlusal orthotic devices provided for the treatment of temporomandibular joint (TMJ) dysfunction. These services are subject to the $50 annual calendar year Deductible. The Maximum amount payable under this program for all TMJ Benefits provided during an Enrollee's lifetime is $500. The TMJ lifetime Maximum is in addition to the $1,500 annual Maximum for other covered Benefits.

ORTHODONTIC BENEFITS

The program also provides payment of 50% of the covered fees for Orthodontic Benefits provided to Enrollees, up to the Maximum of $1,500 for each eligible patient under age 23 and $500 for each eligible patient age 23 and older. The Maximum amount is in addition to the $1,500 annual Maximum for other covered Benefits and is a lifetime Maximum. Orthodontic services are not subject to the Deductible, and amounts paid by an eligible patient for orthodontics will not be credited against the Deductible.

Please refer to the section entitled Covered Fees for additional details.

COVERED FEES

Covered services are available from the employee's or Retiree's eligibility date.

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 by calling 1-800-427-3237.

Payment to a DeltaPreferred Option Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or a fee which the dentist has contractually agreed upon with Delta to accept for treating enrollees under this plan.

Payment to a Delta Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or a fee which the dentist has contractually agreed upon with Delta to accept for treating enrollees under this plan.

Payment to a 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.

If a Dentist discounts, waives, rebates or does not use good faith efforts to collect the portion of the fees entered on the Attending Dentist's Statement from the patient, Delta will not pay more than the applicable percentage stated in the section titled "BENEFITS PROVIDED BY THE PROGRAM" of the lesser of:

(1) the fees entered on the Attending Dentist's Statement, reduced by the portion discounted, waived, rebated or not collected, or:
(2) the Prevailing Fee, reduced by the portion discounted, waived, rebated or not collected.

Payment to a dentist located in another state or outside the United States will be based on the applicable percentage of the lesser of the Fee Actually Charged, or a fee which the dentist has contractually agreed upon with Delta to accept for treating enrollees under this plan. For a dentist who is not a Delta Dentist payment 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.

EXTENSION OF BENEFITS

All Benefits cease on the date coverage terminates except that Delta will pay for Single Procedures, other than orthodontic procedures, which were commenced while eligible.

If an Enrollee is totally disabled when coverage ceases, dental expense benefits will continue to be available during the disability for up to 12 months, but only if expenses incurred represent the charges for covered services which have been rendered and received, including delivered and installed, if applicable, prior to the end of the 12 month period.

However, dental expense Benefits will cease immediately when the individual becomes covered under any group plan with similar benefits, if the coverage terminates for any reason other than discontinuance of the Benefit section as to the eligible class of which the Enrollee is a member.

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.

IDENTIFICATION

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

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

   3999 & 4999

2. The employer's name;

   University of California

3. Campus/Lab Name:

4. Primary Enrollee's or Retiree's member identification number (which must also be used by Dependents).

PAYMENT

Delta is entitled to receive to lawful extents information and records about examinations and treatment provided to you from an attending or examining Dentist, or from hospitals in which a Dentist's care is provided, as may be required in the administration of your claims, or to require that a patient be examined by a dental consultant retained by Delta in or near the patient's community or residence. Delta agrees in every case to hold such information and records as confidential.

Delta will pay Delta Dentists directly. Delta Dental of California's 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).

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

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 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 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 Service department for more information regarding Delta's processing policies.

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 $400, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta 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.

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

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.

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.

FUNDING POLICY AND PAYMENT OF PREMIUMS

The funding policy and method require payment by the Employer to Delta Dental of California as specified in the group dental agreement. If you choose OPTIONAL CONTINUATION OF COVERAGE, you will be required to pay Premiums directly to Delta (or the Delta COBRA Administrator) on or before the first day of each month of continued coverage. The Premiums for a person who elects continued coverage for himself or herself only will be the same as the Employer pays for a single Primary Enrollee plus applicable administration fee. The Premiums for a person who also elects continued coverage for his or her Dependents will be the same as for a Primary Enrollee with the same number of Dependents plus applicable administration fee. If Delta (or the Delta COBRA Administrator) fails to receive Premiums payable on the first day of the month within 30 days thereafter, continued coverage shall be terminated immediately and may not be reinstated by subsequent receipt of Premiums.

NOTICE OF PRIVACY PRACTICES and CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to tell you how Delta and its affiliates ("Delta") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's medical/dental history; mental or physical condition, or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta receives PHI from you, your provider, your employer if the employer sponsors the dental program, a broker or other person involved in the administration of your program, or other persons listed in this notice. Delta receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to Delta's administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice from the privacy official at the plan headquarters that provides your benefits (refer to the Contact section at the end of this notice). You should receive a copy of this notice at the time of enrollment in a Delta program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit program is sponsored by your employer, we may provide PHI to your employer for purposes of administering your benefits unless otherwise prohibited by law. We may disclose PHI to third parties that perform services for Delta in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Delta in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for fundraising and underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- ✓ Uses and/or disclosures of PHI in facilitating treatment.

For example, Delta may use or disclose your PHI to determine eligibility for services requested by your dentist.

- ✓ Uses and/or disclosures of PHI for payment.

  For example, Delta may use and disclose your PHI to bill you or your plan sponsor.

- ✓ Uses and/or disclosures of PHI for health care operations.

  For example, Delta may use and disclose your PHI to review the quality of care provided by our network of dentists.

Disclosures Delta Must Make Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law.

Delta must disclose your PHI without your prior authorization in response to the following:

- ✓ Court order;
- ✓ Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- ✓ Subpoena in a civil action;
- ✓ Investigative subpoena of a government board, commission, or agency;
- ✓ Subpoena in an arbitration;
- ✓ Law enforcement search warrant; or
- ✓ Coroner's request during investigations

Disclosures Delta Makes With Your Authorization

Delta will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Delta or by a person requesting your PHI from Delta.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate Delta plan office from those listed below. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Delta may charge a reasonable fee for providing you copies of your PHI. Delta will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Delta to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the appropriate privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the appropriate privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the appropriate privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the appropriate privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Delta has violated your privacy rights. You may file a complaint with us by notifying the appropriate privacy office as noted below. We will not retaliate against you for filing a complaint.

Contact

You may contact the appropriate Privacy Department at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Subscriber Services
P. O. Box 997330
Sacramento, CA 95899-7330
(877) 335-8273

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