UNIVERSITY OF CALIFORNIA
Employees, Retirees, and their Dependents

EVIDENCE OF COVERAGE AND DISCLOSURE STATEMENT
January 1, 2012

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 Dental”) 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:

website: deltadentalins.com/uc

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

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW 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, Termination and Plan Administration Provisions
January 1, 2012

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

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Dental Health Maintenance Organization (DHMO) Plan, they are only eligible to enroll in the Plan if they meet the Plan's geographic service area criteria as residents of California.

Subscriber

Employee: You are eligible if you have an appointment type which is eligible for benefits, and are a member of the 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 twelve months or more or 2) you have 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.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

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 provided that you also meet the following requirements:

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

A **Survivor**—a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members* or the *Survivor and Beneficiary Handbook*.

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, court documentation confirming a child's status as a legal ward, Federal Income Tax Return, or other official documentation.

Eligible Adult: You may enroll one eligibile adult Family Member, in addition to yourelf:

Spouse: Your legal spouse.

Domestic Partner:

You may enroll your same-sex domestic partner if your partnership is registered with the State of California or otherwise meets criteria as a domestic partnership as set forth in the University of California Group Insurance Regulations. Same-sex domestic partners from jurisdictions other than California will be covered to the extent required by law. You may enroll your opposite-sex domestic partner only if either you or your domestic partner is age 62 or older and eligible to receive Social Security benefits based on age. Your domestic partner (same-sex or opposite sex) must be at least 18 years of age.

Note: An adult dependent relative is not eligible for coverage in UC plans [unless enrolled prior to December 31, 2003 and continuously eligible and enrolled since that date (e.g., continues to be ineligible for Medicare PartA)].

Child: All eligible children must be under the limiting age of 26 (18 for legal wards) except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition). The following categories are eligible:

(a) your natural or legally adopted children;
(b) your spouse's natural or legally adopted children (your stepchildren);
(c) your eligible domestic partner's natural or legally adopted children;
(d) grandchildren of you, your spouse or your eligible domestic partner if unmarried, living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's, or your eligible domestic partner's dependents for income tax purposes;
(e) children for whom you are the legal guardian if unmarried, living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.
(f) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;
- the child is chiefly dependent upon you. your spouse, or your eligible domestic partner for support and maintenance (50% or more); and
- the child is claimed as your, your spouse's or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, is eligible for Social 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.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage, adoption or domestic partnership), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note:
The University complies with federal and state law in administering its group insurance programs. Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). The University also complies with federal and state income tax laws which are subject to change. Requirements may include laws mandating that the employer contribution for coverage provided to certain Family Members be treated as imputed income to the Employee. See At Your Service online for related information. Contact your tax advisor for additional information.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may enroll and 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 eligible 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.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: http://atyourservice.ucop.edu.

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 UC Customer Service Center. Enrollment transactions may be completed by paper form or electronically, 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 UC Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by the deadline on the last day of the enrollment period. Electronic transactions must be completed by the deadline on the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d below). Also see "At Other Times for Employees and Retirees" below. If the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.

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 in which you are enrolled.

(a) For a spouse, on the date of marriage.

(b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.

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

(d) For an adopted child, the earlier of:

(i) the date the child is placed for adoption with the Employee/Retiree, or
(ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

A child is "placed for adoption" with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

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.

(e) For a legal ward, the effective date of the legal guardianship.

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

If you are in a Dental Health Maintenance Organization (DHMO) and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University dental plan available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. Upon return to the service area, you will have a PIE to reenroll yourself and eligible Family Members in the DHMO you had at the time of the move out of the area. The PIE begins with the effective date of the return to the service area.

At Other Times for Employees and Retirees

Open Enrollment Period. You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

Newly Eligible Child. If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

Special Circumstances. You may enroll without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:

   a. You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).

   b. You stated at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above.

   c. Coverage under another health plan for you and/or your eligible Family Members ended because you/they lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, coverage under COBRA or CalCOBRA continuation was exhausted, or coverage under CHIP or Medicaid was lost because you/they were no longer eligible for those programs.

d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**

2. You or your eligible Family Members are not currently enrolled in UC-sponsored dental coverage and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.

3. A court has ordered coverage be provided for a dependent child under your UC-sponsored dental plan pursuant to applicable law and an application is filed within the PIE which begins the date the court order is issued. The child must also meet UC eligibility requirements.

4. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:

   a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.

   b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse (if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

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, and you may change your plan during the University's next open enrollment period. 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). Retirement alone does not grant a PIE to enroll or change your dental plan.

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

<u>Effective Date</u>

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.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

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 Child's enrollment form is received by your local Benefits or Payroll Office.

Change in Coverage
In order to make any of the changes described above, contact the person who handles benefits at your location (or the UC 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 for which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor and your monthly retirement payments covered by a University-sponsored defined benefit plan terminate, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for the retirement income.

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 UC Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement

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

Optional Continuation of Coverage

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act,, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

Contract Termination

Coverage under the Plan is terminated when the group contract between the University and the Plan Vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document.

PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources, 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 group insurance contracts. 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.

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 the President of the University (or his/her delegates) is the Plan Administrator for the Plan provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims and appeals for benefits under the Plan are processed by Delta Dental. If you have a question about benefits under the Plan or about a specific claim, please contact Delta Dental at the following address and phone number:

Delta Dental of California
Delta Tower at 100 First Street
P.O. Box 99730
Sacramento, CA 94899-7330
(800) 777 5854
(415) 972-8300

Group Contract Number
The Group Contract Number for this Plan is: 3999

Type of Plan
This plan provides group dental care benefits. This plan is one of the benefit plans offered under the University of California Health and Welfare Programs for eligible Faculty and Staff.

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 portion of the premiums that 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 Service Agreement.

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 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 Group Service Agreement, 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 file an appeal regarding denied claims of benefits or services, refer to the appeal section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a retiree).

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 of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, 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.

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

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

Contract or Group Dental Contract - the written agreement between Delta Dental 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 Dental will apply Benefit payments, according to the Contract.

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

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

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

Dentist – a duly licensed Dentist legally entitled to practice dentistry when and where services are provided.

Dental Accident – an external blow or other trauma (fall, fist, car accident, gunshot wound, etc.) that would cause severe damage to the dentition, or an internal accident such as biting into glass or a stone that causes severe tooth damage.

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 a claim form, 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 Dental 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 Dental and any other member of the Delta Dental Plans Association with whom Delta Dental 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 Dental used to provide coverage to you and your dependents.

PPO – a preferred provider organization dental product that allows enrollees to choose any dentist, but offers less out of pocket expenses when enrollees visit a contracted Delta Dental PPO dentist. See the definition above for Delta Dental PPO Dentists who participate in this program.

Prevailing Fee– an allowance determined by Delta Dental and/or a Participating Plan for services provided by a dentist who is not a Delta Dental 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 Dental 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 Dental Dentist. This is because his or her fees are approved in advance by Delta Dental. Delta Dental Dentists have treatment forms on hand and will complete and submit the forms to Delta Dental free of charge.

If you choose a Delta Dental PPO Dentist, you will receive all of the advantages of going to a Delta Dental Dentist, and you may have 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 Dental Dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental Dentists should be submitted to Delta Dental at the address listed in this brochure within six months. It is your responsibility to give Delta Dental the required information necessary to evaluate your claim for dental benefits.

A list of Delta Dental PPO Dentists and Delta Dental Dentists can be obtained by calling 1-800-427-3237 or visit our website, deltadentalins.com/uc. This list will identify those dentists who can provide care for individuals who have mobility impairments or have special health care needs. You can obtain specific information about Delta Dental PPO Dentists and Delta Dental Dentists by using our website –deltadentalins.com/uc or by calling the Delta Dental Customer Service department.

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

You should receive timely notification from Delta Dental about whether Benefits will be received under the plan. If Delta Dental 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 Dental claim forms. 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 Dental 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 Dental shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta Dental cannot ensure your dentist's use of precautions against the spread of such diseases, or compel your dentist to be tested for HIV or to disclose test results to Delta Dental, or to you. Delta Dental informs its panel dentists about the need for clinical precautions as recommended by recognized health authorities on this issue. If you should have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

SECOND OPINIONS

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

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

GRIEVANCE PROCEDURE AND CLAIMS APPEAL

If an Enrollee has any questions about the services received from a Delta Dental Dentist, Delta Dental 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 Dental. Delta Dental 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 Dental, or the quality of dental services performed by a Delta Dental Dentist, he or she may call Delta Dental toll-free at 1-800-777-5854, contact Delta Dental on the Internet through the website: deltadentalins.com/uc or write Delta Dental 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 Dental 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 Dental 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 Dental'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 Dental's regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Delta Dental'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 Dental 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 Dental shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

Delta Dental will provide the Enrollee a written acknowledgement within 5 days of receipt of the request for review. Delta Dental will make a written decision within 30 days of receipt of the request for review, or inform the Enrollee of the pending status if more information or time is needed to resolve the matter. Delta Dental 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 Dental's grievance procedure or after he or she has been involved in Delta Dental'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 Website **(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 Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Delta Dental of California, Customer Service department, P. O. Box 997330, Sacramento, CA 95899-7330.

COORDINATION OF BENEFITS (DUAL COVERAGE)

If a group insurance policy or any other group health Benefits program, including another Delta Dental 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 Dental will provide Benefits as if the other program did not exist. If the other program is "primary" under these rules, then Delta Dental 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 Dental 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 Dental with any information about the person that is needed to administer this Article, and Delta Dental 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 Dental 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 Dental will be Benefits under this Contract. Delta Dental has the right to recover the value of any Benefits provided by Delta Dental which exceed its obligations under the terms of this provision from a Delta Dental Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses.

CANCELLATION AND RENEWAL

This Dental Care Program may be canceled by Delta Dental 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 Dental 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 Dental.

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.** These services are provided after the Deductible is met and up to Maximum amounts as outlined in the section **AMOUNT OF BENEFITS PAYABLE.**

I. PREVENTIVE BENEFITS –
100% of the Delta Dental PPO Dentist or Delta Dental Premier Dentist fees
100% of the Delta Dental allowance for non-Delta Dental Dentists

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

Note on additional Benefits during pregnancy. If you are pregnant, Delta Dental will pay for additional services to help improve your oral health during pregnancy. The additional services each calendar year while you are eligible in this Delta Dental plan include: one additional oral examination and either one additional routine cleaning or one additional periodontal scaling and root planing per quadrant. Written confirmation of your pregnancy must be provided by you or your dentist when the claim is submitted.

OTHER PREVENTIVE BENEFITS –
100% of the Delta Dental PPO Dentist fees
75% of the Delta Dental allowance for Delta Dental Premier Dentists and non-Delta Dental Dentists

Pit and fissure sealants – see limitation (h).

II. BASIC BENEFITS –
80% of the Delta Dental PPO Dentist fees
75% of the Delta Dental allowance for Delta Dental Premier Dentists and non-Delta Dental 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.

I.V. sedation

Prosthodontic appliance repair

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

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

IV. PROSTHODONTIC BENEFITS –
50% of the Delta Dental PPO Dentist or Delta Dental Premier Dentist fees
50% of the Delta Dental allowance for non-Delta Dental Dentists

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

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

V. ORTHODONTIC BENEFITS –
50% of the Delta Dental PPO Dentist or Delta Dental Premier Dentist fees
50% of the Delta Dental allowance for non-Delta Dental Dentists

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

VI. TEMPOROMANDIBULAR JOINT (TMJ) BENEFITS – 50% of the Delta Dental PPO Dentist or Delta Dental Premier Dentist fees 50% of the Delta Dental allowance for non-Delta Dental 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 Dental 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 you are eligible under any Delta Dental Program. See Note on additional Benefits during pregnancy on page 22.

b) Non-routine oral examinations shall not be provided more than twice in a calendar year while you are eligible under any Delta Dental program. See Note on additional Benefits during pregnancy on page 22.

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 Dental program.

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

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 Dental program (including non-University Delta Dental programs).

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 Dental 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 o). See Note on additional Benefits during pregnancy on page 22.

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. See Note on additional Benefits during pregnancy on page 22.

k) Crowns, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are eligible under any Delta Dental program, unless Delta Dental 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) and implants are Benefits only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan will be made if it is unsatisfactory and cannot be made satisfactory. Delta Dental will replace an implant, a prosthodontic appliance or an implant supported prosthesis you received under another dental plan if we determine it is unsatisfactory and cannot be made satisfactory. We will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.

m) Delta Dental 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) 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 Dental program. Additional cleanings may be allowed By Report if documentation demonstrates that the procedure is clinically necessary. See Note on additional Benefits during pregnancy on page 22.

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

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

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

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

r) 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.

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

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

u) 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 Dental 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.

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

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

x) If your medical plan does not cover any particular claim for Dental Accident benefits, either in whole or in part, Delta Dental will pay based on your current plan design, subject to all limitations and annual maximum benefits. Your medical plan's customer service representatives will be able to confirm the coverage for Dental Accidents that your medical plan provides.

EXCLUSIONS/SERVICES WE DO NOT COVER

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

Delta Dental does not provide benefits for:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws, 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 or I.V. sedation given by a dentist for covered oral surgery procedures and select Endodontic and Periodontic 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. 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.

11. 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.

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

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

14. Services provided by a relative.

15. Gingival curettage.

16. 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 $1,700 for services provided by a Delta Dental PPO Dentist or $1,500 for services provided by a non-Delta Dental PPO Dentist** (details below) for each Enrollee in each calendar year for the following Benefits:

Preventive Benefits .... 100% PPO/100% non-PPO
Other Preventive Benefits .... 100% PPO/75% non-PPO
(Pit and Fissure Sealants)
Basic Benefits .... 80% PPO/75% non-PPO
(Restorative, Oral Surgery, Endodontics, Periodontics, General anesthesia, Prosthetic Appliance Repair)
Crowns, Inlays, Onlays, and Cast Restoration Benefits.................... 50% PPO/50% non-PPO
Prosthodontic Benefits .... 50% PPO/50% non-PPO

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.

Calendar Year Maximum: All Benefits listed above and Dental Accident Benefits are subject to a calendar year Maximum of $1,700 for services provided by a Delta Dental PPO Dentist or $1,500 for services provided by a non-Delta Dental PPO Dentist per covered enrollee. TMJ and Orthodontic Benefits are not subject to the calendar year Maximum, however are subject to a separate lifetime Maximum as listed below.

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 26 and $500 for each eligible patient age 26 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.

DENTAL IMPLANTS

Dental implant procedures are a benefit covered under Prosthodontic Benefits under your program.

DENTAL ACCIDENT BENEFITS

Services necessary as a result of a dental accident (a condition caused directly by external, violent or accidental means) may be covered as primary under your medical coverage. All claims should first be submitted to your medical carrier for review and possible payment, prior to submitting them under your Delta Dental plan.

Questions regarding these fees should be directed to Delta Dental's Customer Service department at 1 (800) 777-5854.

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 Dental 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 Dental Dentist.

A list of Delta Dental Dentists (see DEFINITIONS) is available by calling 1-800-427-3237.

Payment to a Delta Dental PPO 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 Dental to accept for treating enrollees under this plan.

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

Payment to a dentist who is not a Delta Dental Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the fee which satisfies the majority of Delta Dental'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 claim form from the patient, Delta Dental 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 claim form, 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 Dental to accept for treating enrollees under this plan. For a dentist who is not a Delta Dental 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 Dental's Dentists.

EXTENSION OF BENEFITS

All Benefits cease on the date coverage terminates except that Delta Dental 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 Dental 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 Dental group number (on the front of this booklet);

   3999 (Employees and dependents)
   4999 (COBRA enrollees)

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).

You can print an I.D. card with this information by visiting our website at deltadentalins.com/uc.

REIMBURSEMENT PROVISIONS

Delta Dental 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 Dental in or near the patient's community or residence. Delta Dental agrees in every case to hold such information and records as confidential.

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

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

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

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

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

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

The process Delta Dental uses to determine or deny payment for services are distributed to all Delta Dental 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 Dental's dentist consultants. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dental Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta Dental's Customer Service department for more information regarding Delta Dental's processing policies.

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

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

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

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

Maximums can also be affected when the amount paid for services provided by Delta Dental PPO Dentists is higher than the maximum paid for services provided by non-PPO dentists. For example, if the Delta Dental PPO Plan's annual Maximum is $1,700 and the maximum for services provided by non-PPO dentists is $1,500 and Delta Dental has paid $1,500 or more dollars for covered dental services, you do not qualify for any further payments for services provided by non-PPO dentists. But, if any other covered services are provided by a Delta Dental PPO Dentist, you qualify for an additional $200.

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

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

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

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.

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 Dental and its affiliates ("Delta Dental") 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, ID number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records.

Delta Dental 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 Dental 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 Dental'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 Dental 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 Dental 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 Dental 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 Dental 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 Dental 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 Dental may use and disclose your PHI to review the quality of care provided by our network of dentists.

Disclosures Delta Dental 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 Dental 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 Dental Makes With Your Authorization

Delta Dental 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 Dental or by a person requesting your PHI from Delta Dental.

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 Dental 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 Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental 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 Dental 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 Dental 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 Dental 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

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 1-800-765-6003. You may also be able to receive this document in Spanish or Chinese.

IMPORTANTE: ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 1-800-765-6003. También puede recibir este documento en español o chino.

重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。 如需免費協助，請電Delta Dental 1-800-765-6003 您也能取得這份文件的西班牙文或中文譯本。

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