KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

INDIVIDUAL DENTAL INSURANCE POLICY

IMPORTANT NOTICE:
This dental insurance plan is an excepted benefit plan and is not intended to comply with pediatric dental coverage required by the Affordable Care Act (ACA).

POLICYHOLDER:	[JOHN DOE]
ADDRESS:	[123 Main Street Anytown, CA 00000]
POLICY NUMBER:	[x – xxxxxx]
POLICY EFFECTIVE DATE:	[January 1, 1997]
POLICY ANNIVERSARY:	[January 1 of each year thereafter]

The insurance Policy is delivered in the State of California.

Kaiser Permanente Insurance Company (herein called KPIC) agrees to pay the benefits for services rendered to Insureds, in accordance with the provisions and conditions set forth under this Policy. The terms "You" or "Your" when they appear in this Policy, refer to the Policyholder. The terms "we", "us", or "our", when they appear in this Policy, refer to KPIC.

CAUTION: This Policy is issued in consideration of the application form and the Policyholder's payment of premiums as provided under this Policy. A copy of your application is on file with us and can be furnished to You upon request.. If your answers are misstated or untrue, Kaiser Permanente Insurance Company (KPIC) may have the right to deny benefits or rescind your Policy . The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact KPIC at this address: Kaiser Permanente Insurance Company, One Kaiser Plaza, Oakland California, 94612.

This policy and the insurance it provides become effective 12:01a.m. (Your time) on the Policy Effective Date shown above. This policy and the insurance it provide terminate at 12:00 midnight (Your time) on the date of termination.

This Policy describes the dental coverage, which is provided in conjunction with the health care coverage provided by Kaiser Permanente Insurance Company and Kaiser Foundation Health Plan under the Policy between KPIC and KFHP.

The benefits described under this Policy are provided on an equal access basis without regard to race, color, national origin, religion, disability, age, sex, gender identity, or sexual orientation.

YOUR 10 DAY RIGHT TO EXAMINE YOUR POLICY: If you are not satisfied with your Policy, you may return it to us, along with your Identification cards, by delivering or mailing it to: KPIC's dental Administrator, Delta Dental of California at PO Box 997330, Sacramento, CA 95899 within 10 days after you receive it. We will then refund any premium you have paid within 30 days of our receipt of the Policy and the Policy will be considered void from the beginning.

Read this Policy carefully. It is a legal contract between you and us.

President

INTRODUCTION

INTRODUCTION

IMPORTANT NOTICE

If you require this Policy of Insurance, or any other document issued to you in connection with this dental insurance coverage printed in another language other than English, please call 1(800)-835-2244. Translated documents and language interpretation may be available. The English version of the Policy of Insurance is the official version. The foreign language version is for informational purposes only.

Please refer to the General Exclusions section of this Policy for a description of the plan's general limitations and exclusions. Likewise, the Table of Allowances contains specific limitations for specific benefits.

There are terms that have very specific definitions for the purpose of this Insurance Policy. These terms are defined in the General Definitions section and are capitalized so that You can easily recognize them. Other parts of this Policy may contain definitions specific to those provisions. Terms that are used only within one section of this Policy are defined in those sections. Please read all definitions carefully.

This Policy includes a Table of Allowances that will give You a quick overview of Your coverage. It is very important, however, that You read Your entire Policy for a more complete description of Your coverage and the exclusions and limitations under this medical insurance plan.

Who Can Answer Your Questions?

For assistance with questions regarding Your coverage such as Your Benefits, Your current eligibility status or name and address changes, please have Your ID card available when You call:

Customer Services Department 1-800-835-2244

Or You may write to Our Administrator at :

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899

Or You may contact Our Administrator, Delta Dental, on the Internet at: www.deltadentalins.com

HOW THE PLAN WORKS

The following section of this Policy, You will find the Table of Allowances section which lists dental procedures and/or dollar amounts ("Plan Pays"). By referring to this table, You will be able to determine exactly how much KPIC will pay toward any given procedure.

During a typical dental office visit, You might receive several of the services listed in Your Table of Allowances.

After each claim is submitted, You will receive a statement from KPIC or its Administrator, explaining which services were provided, what KPIC will pay and the amount You are responsible for paying.

Deductible/Maximum

You must first pay charges for Covered Services until you satisfy your Deductible. Please refer to the Table of Allowances for the Deductible amount, if any, for you and for Your family. There is no Deductible on diagnostic and preventive services.

Choosing Your Dentist

Although You may choose any dentist, You get special advantages when You go to Participating Dentists. These dentists have agreed to handle all Your claims paperwork for You, and to charge only fees that have been approved by KPIC or its Administrator. KPIC reimburses Participating Dentists directly, so You are responsible only for the allowed amount not covered by the Table of Allowances. If You go to a non-Participating Dentist, You are responsible for the entire bill and must submit a claim to KPIC's Administrator for reimbursement of covered dental procedures. KPIC's Administrator will reimburse You directly in accordance with the Table of Allowances.

For a complete list of Participating Dentists in Your area, see Your benefits administrator or call 1-800-835-2244, or you may visit KPIC's contracted dental network at www.deltadentalins.com.

Written notice of the occurrence or commencement of covered services, treatment and supplies must be provided to KPIC or its Administrator within 20 days after such loss, or as soon as is reasonably possible. Written proof of such loss must be proved to KPIC or its Administrator within 90 days after such loss. Failure to provide such proof shall neither invalidate nor reduce any claim if it is not reasonably possible to furnish such proof within such time, provided such proof is provided as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. If a claim is denied due to a Participating 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 KPIC, provided that You advised the dentist of Your eligibility at the time of treatment.

If You Have Questions About Service From a Participating Dentist

If You have questions about the services You receive from a Participating Dentist, We recommend that You first discuss the matter with Your dentist. If You continue to have concerns, call Our Administrator's Quality Review department at 1-800-835-2244. If appropriate, KPIC's Administrator can arrange for You to be examined by one of its consulting dentists in Your area. If the consultant recommends the work be replaced or corrected, KPIC's Administrator will intervene with the original dentist to either have the services replaced or corrected at no additional cost to You or to obtain a refund. In the latter case, You are free to choose another dentist to receive Your full benefits.

KPIC Dental Insurance Plan
TABLE OF ALLOWANCES
(List of the amounts KPIC will pay)

(Maximum Amount Payable by KPIC For Covered Dental Services)

Calendar Year Benefit Maximum: $1,000.00
Calendar Year Deductibles:
Individual: $25.00
Family: $75.00

Code	Procedure	Allowance
D0100-D0999	**DIAGNOSTIC**	
	Clinical oral evaluations	
D0120	Periodic oral evaluation	18.00
D0140	Limited oral evaluation – problem focused	25.20
D0150	Comprehensive oral evaluation – new or established patient	25.20
D0160	Detailed and extensive oral evaluation, problem focused	21.00
D0170	Reevaluation limited problem focused (established patient; not post operative visit)	21.00
D0180	Comprehensive periodontal evaluation – new or established patient	21.00
	Pre-Diagnostic Services	
D0190	Screening of a patient	12.60
D0191	Assessment of a patient	12.60
	Radiographs/diagnostic imaging (including interpretation)	
D0210	Intraoral – complete series of radiographic images	54.00
D0220	Intraoral periapical – first radiographic image	12.00
D0230	Intraoral periapical – each additional radiographic image	5.00
D0240	Intraoral – occlusal radiographic image	12.00
D0250	Extraoral – first radiographic image	19.00
D0270	Bitewing – single radiographic image	11.00
D0272	Bitewings – two radiographic images	17.00
D0273	Bitewings – three radiographic images	20.50
D0274	Bitewings – four radiographic images	24.00
D0277	Vertical bitewings – 7 to 8 radiographic images	45.00
D0330	Panoramic radiographic image	37.00
	Oral pathology laboratory	
D0419	Assessment of salivary flow by measurement	2.00
D0472	Accession of tissue, gross examination, preparation and transmission of written report	59.00
D0473	Accession of tissue, gross & microscopic examination, preparation and transmission of written report	59.00
D0474	Accession of tissue, gross & micro exam, assessment of surgical margins for presence of disease, preparation and transmission of written report	59.00
	Risk assessment	
D0601	Caries risk assessment and documentation, with finding of low risk	3.00
D0602	Caries risk assessment and documentation, with finding of moderate risk	3.00
D0603	Caries risk assessment and documentation, with finding of high risk	3.00

KPIC Dental Insurance Plan
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Code	Procedure	Allowance
D1000-D1999 PREVENTIVE		
Dental prophylaxis		
D1110	Prophylaxis – adult	43.20
Other preventive services		
D2000-D2999 RESTORATIVE – Procedures subject to 6 month waiting period		
Amalgam restorations (including polishing)		
D2140	Amalgam – one surface, primary or permanent	35.00
D2150	Amalgam – two surfaces, primary or permanent	43.00
D2160	Amalgam – three surfaces, primary or permanent	52.00
D2161	Amalgam – four or more surfaces, primary or permanent	58.00
Resin – based composite restorations – direct		
D2330	Resin-based composite – one surface, anterior	46.00
D2331	Resin-based composite – two surfaces, anterior	46.00
D2332	Resin-based composite – three surfaces, anterior	46.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	68.00
D2390	Resin-based composite crown, anterior	114.00
D2391	Resin-based composite – one surface, posterior	47.00
D2392	Resin-based composite – two surfaces, posterior	64.00
D2393	Resin-based composite – three surfaces, posterior	80.00
D2394	Resin-based composite – four or more surfaces, posterior	80.00
Inlay/onlay restorations		
D2510	Inlay – metallic – one surface	99.00
D2520	Inlay – metallic – two surfaces	133.00
D2530	Inlay – metallic – three or more surfaces	150.00
D2542	Onlay – metallic – two surfaces	191.00
D2543	Onlay – metallic – three surfaces	191.00
D2544	Onlay – metallic – four or more surfaces	191.00
D2650	Inlay – resin-based composite – one surface……..	34.00
D2651	Inlay – resin-based composite – two surfaces	50.00
D2652	Inlay – resin-based composite – three or more surfaces……..	63.00
D2662	Onlay – resin-based composite – two surfaces	50.00
D2663	Onlay – resin-based composite – three surfaces	63.00
D2664	Onlay – resin-based composite – four surfaces	63.00
Crowns – single restoration only		
D2710	Crown – resin-based composite (indirect)	80.00
D2712	Crown – ¾ resin-based composite (indirect) ……....	80.00
D2720	Crown – resin with high noble metal	182.00
D2721	Crown – resin with predominantly base metal	163.00
D2722	Crown – resin with noble metal	177.00
D2740	Crown – porcelain/ceramic substrate	192.00
D2750	Crown – porcelain fused to high noble metal	182.00
D2751	Crown – porcelain fused to predominantly base metal	163.00
D2752	Crown – porcelain fused to noble metal	177.00
D2753	Crown – porcelain fused to titanium and titanium alloys	182.00
D2780	Crown – ¾ cast high noble metal	186.00
D2781	Crown – ¾ cast predominantly base metal	186.00

KPIC Dental Insurance Plan
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Code	Procedure	Allowance
D2782	Crown – ¾ cast noble metal	186.00
D2790	Crown – full cast high noble metal	183.00
D2791	Crown – full cast predominantly base metal	170.00
D2792	Crown – full cast noble metal	178.00
D2794	Crown titanium	183.00
Other restorative services		
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	27.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	27.00
D2920	Re-cement or re-bond crown	27.00
D2921	Reattachment of tooth fragment, incisal edge or cups	51.00
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	74.00
D2931	Prefabricated stainless steel crown – permanent tooth	74.00
D2932	Prefabricated resin crown	80.00
D2933	Prefabricated stainless steel crown with resin window	90.00
D2950	Core buildup, including any pins when required	43.00
D2951	Pin Retention – per tooth, in addition to restoration	20.00
D2952	Post and core in addition to crown, indirectly fabricated	92.00
D2954	Prefabricated post and core in addition to crown	75.00
D2960	Labial veneer (resin laminate) – chairside	116.00
D2961	Labial veneer (resin laminate) – laboratory	128.00
D2962	Labial veneer (porcelain laminate) – laboratory	161.00
D2980	Crown repair - necessitated by restorative material failure	25.00
D3000-D3999 ENDODONTICS – Procedures subject to 6 month waiting period		
Pulpotomy		
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	38.00
D3221	Pulpal debridement primary/or permanent teeth	41.00
D3222	Partial pulpotomy – for apexogenesis - permanent tooth with incomplete root development	38.00
D3230	Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)	38.00
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	38.00
Endodontic therapy (including treatment plan, clinical procedures, and follow-up care)		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	193.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	227.00
D3330	Endodontic therapy, molar tooth (excluding final restoration)	306.00
D3333	Internal root repair of perforation defects	56.00

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Code	Procedure	Allowance
Endodontic retreatment		
D3346	Re-treatment of previous root canal therapy – anterior…….	193.00
D3347	Re-treatment of previous root canal therapy – bicuspid	227.00
D3348	Re-treatment of previous root canal therapy – molar	306.00
D3351	Apexification/re-calcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	56.00
D3352	Apexification/re-calcification – interim medication replacement	56.00
D3353	Apexification/re-calcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	56.00
Apicoectomy/periradicular services		
D3410	Apicoectomy– anterior	240.00
D3421	Apicoectomy– bicuspid (first root)	257.00
D3425	Apicoectomy– molar (first root)	294.00
D3426	Apicoectomy (each additional root)	50.00
D3430	Retrograde filling – per root	57.00
D3450	Root amputation – per root……	166.00
D3471	Surgical repair of root resorption – anterior ……	57.00
D3472	Surgical repair of root resorption – premolar ……	57.00
D3473	Surgical repair of root resorption – molar ……	57.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	57.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	57.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	57.00
Other endodontic services		
D3920	Hemisection (including any root removal), not including root canal therapy……	121.00
D3921	Decoronation of submergence of an erupted tooth……	39.00

D4000-D4999 PERIODONTICS - Procedures subject to 6 month waiting period

Surgical services (including usual postoperative services).		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	128.00
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces, per quadrant	77.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	77.00
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	159.00
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces, per quadrant	95.00
D4245	Apically positioned flap	159.00
D4249	Clinical crown lengthening – hard tissue	96.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	342.00

KPIC Dental Insurance Plan
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Code	Procedure	Allowance
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces, per quadrant	205.00
D4263	Bone replacement graft – first site in quadrant	62.00
D4264	Bone replacement graft – each additional site in quadrant	47.00
D4266	Guided tissue regeneration – resorbable barrier, per site	135.00
D4267	Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)	135.00
D4268	Surgical revision procedure, per tooth	135.00
D4270	Pedicle soft tissue graft procedure	192.00
D4273	Subepithelial connective tissue graft procedures, per tooth	233.00
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	208.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	156.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	140.00
D4286	Removal of non-resorbable barrier	27.00
	Non-surgical periodontal service	
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	59.00
D4342	Periodontal scaling and root planning – one to three teeth, per quadrant	35.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	43.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	36.00
	Other periodontal services	
D4910	Periodontal maintenance	41.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	36.00
	D5000-D5999 PROSTHODONTICS, REMOVABLE – procedures are subject to a 12 month waiting period	
	Complete dentures (including routine post-delivery care)	
D5110	Complete denture – maxillary	240.00
D5120	Complete denture – mandibular	241.00
D5130	Immediate denture – maxillary	240.00
D5140	Immediate denture – mandibular	241.00
	Partial dentures (including routine post-delivery care)	
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	203.00
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	212.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	287.00

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Code	Procedure	Allowance
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	287.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	216.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests, or	
D5228	teeth)…….	216.00
	Immediate mandibular partial denture – flexible base (including any clasps, rests, and	260.00
	teeth)..	259.00
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	120.00
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	120.00
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	108.00
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	108.00
Adjustments to dentures		
D5410	Adjust complete denture – maxillary	13.00
D5411	Adjust complete denture – mandibular	13.00
D5421	Adjust partial denture – maxillary	14.00
D5422	Adjust partial denture – mandibular	14.00
Repairs to complete dentures		
D5511	Repair broken complete denture base, mandibular	31.00
D5512	Repair broken complete denture base, maxillary	31.00
D5520	Replace missing or broken teeth – complete denture (each tooth)	25.00
Repairs to partial dentures		
D5611	Repair resin partial denture base,	
	mandibular…….	30.00
D5612	Repair resin partial denture base,	
	maxillary ……..	30.00
D5621	Repair cast partial framework, mandibular	25.00
D5622	Repair cast partial framework, maxillary	25.00
D5630	Repair or replace broken clasp	36.00
D5640	Replace broken teeth – per tooth	27.00
D5650	Add tooth to existing partial denture	31.00
D5660	Add clasp to existing partial denture	37.00
Denture rebase procedures		
D5710	Rebase complete maxillary denture	94.00
D5711	Rebase complete mandibular denture	93.00
D5720	Rebase maxillary partial denture	89.00
D5721	Rebase mandibular partial	91.00
D5725	denture……	89.00
	Rebase hybrid	
	prosthesis……..	
Denture reline procedures		
D5730	Reline complete maxillary denture (chairside)	46.00
D5731	Reline complete mandibular denture (chairside)	45.00
D5740	Reline maxillary partial denture (chairside)	45.00
D5741	Reline mandibular partial denture (chairside)	47.00
D5750	Reline complete maxillary denture (laboratory)	70.00

Code	Procedure	Allowance
D5751	Reline complete mandibular denture (laboratory)	70.00
D5760	Reline maxillary partial denture (laboratory)	71.00
D5761	Reline mandibular partial denture (laboratory)	71.00
D5765	Soft liner for complete or partial removeable denture – indirect……..	71.00
Interim prosthesis		
D5820	Interim partial denture (maxillary)	85.00
D5821	Interim partial denture (mandibular)	85.00
Other removable prosthetic services		
D5850	Tissue conditioning, maxillary	25.00
D5851	Tissue conditioning, mandibular	24.00
D5863	Overdenture – complete maxillary…….	240.00
D5864	Overdenture – partial maxillary…….	287.00
D5865	Overdenture – complete mandibular……	241.00
D5866	Overdenture – partial mandibular……	287.00
D6200-D6999 PROSTHODONTICS, FIXED - Procedures subject to a 6 month waiting period		
(Each retainer and each pontic constitutes a unit in a fixed partial denture.)		
Fixed partial denture pontics		
D6210	Pontic – cast high noble metal	171.00
D6211	Pontic – cast predominantly base metal	138.00
D6212	Pontic – cast noble metal	168.00
D6214	Pontic – titanium ……..	171.00
D6240	Pontic – porcelain fused to high noble metal	176.00
D6241	Pontic – porcelain fused to predominantly base metal	155.00
D6242	Pontic – porcelain fused to noble metal	170.00
D6243	Pontic – porcelain fused to titanium and titanium alloys	170.00
D6250	Pontic – resin with high noble metal	176.00
D6251	Pontic – resin with predominantly base metal	155.00
D6252	Pontic – resin with noble metal	170.00
Fixed partial denture retainers – inlays/onlays		
D6545	Retainer – cast metal for resin bonded fixed prosthesis	88.00
D6549	Resin Retainer- resin bonded fixed prosthesis	88.00
D6602	Retainer Inlay – cast high noble metal, two surfaces	121.00
D6603	Retainer Inlay – cast high noble metal, three or more surfaces	135.00
D6604	Retainer Inlay – cast predominantly base metal, two surfaces	121.00
D6605	Retainer Inlay – cast predominantly base metal, three or more surfaces	135.00
D6606	Retainer Inlay – cast noble metal, two surfaces	121.00
D6607	Retainer Inlay – cast noble metal, three or more surfaces	135.00
D6610	Retainer Onlay – cast high noble metal, two surfaces	288.00
D6611	Retainer Onlay – cast high noble metal, three or more surfaces	288.00
D6612	Retainer Onlay – cast predominantly base metal, two surfaces	288.00
D6613	Retainer Onlay – cast predominantly base metal, three or more surfaces	288.00

KPIC Dental Insurance Plan
TABLE OF ALLOWANCES
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Code	Procedure	Allowance
D6614	Retainer Onlay – cast noble metal, two surfaces	288.00
D6615	Retainer Onlay – cast noble metal, three or more surfaces	288.00
D6624	Retainer Inlay – titanium	135.00
D6634	Onlay – titanium	288.00
Fixed partial denture retainers – crowns		
D6720	Retainer Crown – resin with high noble metal	181.00
D6721	Retainer Crown – resin with predominantly base metal	161.00
D6722	Retainer Crown – resin with noble metal	175.00
D6750	Retainer Crown – porcelain fused to high noble metal	181.00
D6751	Retainer Crown – porcelain fused to predominantly base metal	161.00
D6752	Retainer Crown – porcelain fused to noble metal	175.00
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	181.00
Fixed partial denture retainers – crowns		
D6780	Retainer Crown – ¾ cast high noble metal	181.00
D6781	Retainer Crown – ¾ cast predominantly base metal	181.00
D6782	Retainer Crown – ¾ cast noble metal	181.00
D6784	Retainer crown ¾ – titanium and titanium alloys	180.00
D6790	Retainer Crown – full cast high noble metal	180.00
D6791	Retainer Crown – full cast predominantly base metal	159.00
D6792	Retainer Crown – full cast noble metal	175.00
D6794	Retainer Crown – titanium	180.00
Other fixed partial denture services		
D6930	Re-cement or re-bond fixed partial denture	33.00
D6940	Stress breaker	38.00
D6980	Fixed partial denture repair necessitated by restorative material failure	50.00
D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY Procedures subject to a 6 month waiting period		
Extractions (includes local anesthesia, suturing, suturing, if needed, and routine postoperative care)		
D7111	Extraction, coronal remnants – deciduous tooth	20.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	39.00
Surgical extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7210	Surgical removal of erupted tooth requiring removal of bone and/or section of tooth, and including elevation of mucoperiosteal flap if indicated	74.00
D7220	Removal of impacted tooth – soft tissue	90.00
D7230	Removal of impacted tooth – partially bony	117.00
D7240	Removal of impacted tooth – completely bony	134.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	78.00
Other surgical procedures		
D7260	Oroantral fistula closure	225.00
D7261	Primary closure of a sinus perforation	225.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	132.00

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Code	Procedure	Allowance
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	98.00
D7280	Surgical access of unerupted tooth	176.00
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	136.00
D7286	Incisional biopsy of oral tissue – soft	108.00
	Alveoloplasty – surgical preparation of ridge for dentures	
D7310	Alveoloplasty in conjunction with extractions – per quadrant	59.00
D7311	Alveoloplasty in conjunction with extractions –one to three teeth or tooth spaces, per quadrant ……..	36.00
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	96.00
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant ……	58.00
	Vestibuloplasty	
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	82.00
D7350	Vestibuloplasty – ridge extension (including soft tissue graft, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	218.00
	Surgical excision of intra-osseous lesions	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	131.00
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	273.00
	Excision of bone tissue	
D7471	Removal of lateral exostosis (maxilla or mandible)	162.00
D7472	Removal of torus palatinus	162.00
D7473	Removal of torus mandibularis	162.00
	Surgical incision	
D7509	Marsupialization of odontogenic	
D7510	cyst……	273.00
	Incision and drainage of abscess – intraoral soft tissue	48.00
D7961	Buccal/labial frenectomy (frenulectomy)	115.00
D7962	lingual frenectomy (frenulectomy)	115.00
D7970	Excision of hyperplastic tissue – per arch	88.00
D7971	Excision of pericoronal gingival	43.00
	D9000-D9999 ADJUNCTIVE GENERAL SERVICES	
	Unclassified treatment	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	41.00

KPIC Dental Insurance Plan
TABLE OF ALLOWANCES
(List of the amounts KPIC will pay)

Code	Procedure	Allowance
Anesthesia		
D9222	Deep sedation/general anesthesia – first 15 minutes	36.00
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	36.00
Professional consultation		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	43.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	24.00
D9440	Office visit – after regularly scheduled hours	49.00
Drugs		
D9610	Therapeutic parenteral drug injection, single administration	6.00
D9612	Therapeutic parental drugs, two or more administrations, different medications	6.00
Miscellaneous services		
D9930	Treatment of complications (postsurgical) – unusual circumstances, by report	19.00
D9951	Occlusal adjustment – limited	32.00

Note: Codes in this Table of Allowances represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT) in effect at the date of this Contract or amendment was issued. CDT coding and nomenclature are the copyright of the American Dental Association, and have been accepted as the standard for data transmission purposes under federal Administrative Simplification regulations. For the purposes of this Table of Allowances, the administration of Benefits, Limitations and Exclusions under this Policy will at all times be based on the then-current version of CDT whether or not a revised Table of Allowance is provided.

GENERAL POLICY PROVISIONS

Insuring Agreement

We promise to pay the benefits described in this Policy. The payment of all these benefits is subject to all: definitions; limitations; and provisions of this Policy. We make this promise and issue this Policy in consideration of: (1) the statements made in your signed application form, a copy of which is attached and made part of this Policy; and (2) payment of the initial premium.

Entire Contract and Changes

The entire contract between You and KPIC consists of this Policy, riders, amendments, endorsements, and the application form. All statements made by You will, in the absence of fraud, be deemed representations and not warranties. This means that the statements are made in good faith. No statement or omission will void this policy, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or electronic application. A copy of your application is on file with us and can be furnished to You upon request.

No change in the Policy will be valid unless:

1. It is noted on, or attached to, this Policy.
2. Signed by an executive officer of KPIC; and
3. Delivered to the Policyholder.

KPIC may change, cancel, or discontinue coverage, to the extent permitted by law, provided under this Policy without Your consent. Payment of premium, after a change has been made and incorporated into the Policy, will be deemed acceptance of the changes made by KPIC. Notice to You will be considered notice to any of Your insured Dependent(s).

No agent has the authority to:

1. Change the Policy;
2. Waive any provisions of the Policy;
3. Extend the time for payment of premiums; or
4. Waive any of KPIC's rights or requirements.

The Policyholder designates sole discretion to KPIC to interpret and determine provisions of this Policy.

Administrator

This Policy is administered by Delta Dental Plan of California (Delta Dental), PO Box 997330, Sacramento, CA 95899 KPIC reserves the right to change the Administrator at any time during the term of this Policy without prior notice.

Individual Policy

Depending on what option You've agreed upon with Us, individual Policy will be issued to You either via United State Postal Service or electronically via *email or web*. We will only issue the Policy during the initial year of your coverage, unless we determine that any subsequent change or revision to the Policy is material, in which case a new Policy will be issued. If we determine that the revision is not material, any subsequent revision to the Policy may be effected via a rider or an endorsement. Unless otherwise noted, the provisions described in riders or endorsements are controlled by the provisions of the Policy initially issued to You. Please keep the Policy and any rider or endorsement in a safe place. Notwithstanding this provision, you can always call the number in your ID card for a copy of your Insurance Policy.

Policy Renewal

The Policy is renewable on each Anniversary date subject to the termination provisions, as set forth in this Individual Dental Policy.

GENERAL POLICY PROVISIONS

Notice Required

Any notice this Policy permits or requires to be given to You or to Us shall be in writing and given to:

1. You at the address shown in this Policy or the last address we have in our records;
2. KPIC or KPIC's Administrator at the address listed in this Policy.

Written notice to You will be deemed to be effective on the date it is placed in the United States Mail, postage prepaid and properly addressed to the primary location of the Policyholder. Notice will be deemed to be properly addressed if it reflects the last address shown in KPIC's records.

Conformity with State Statutes

This Policy will be interpreted by the laws of the state in which it is delivered. Any part of this Policy that is in conflict with the laws of the state in which it is delivered, or any other applicable state or federal law, is changed to conform to the minimum requirements of the applicable state or federal law.

Incontestability

Any statement made by the Policyholder in applying for insurance under this Policy will be considered a representation and not a warranty. After two (2) years from the date of issue of this Policy, no misstatements, except for non payment of premium or fraudulent misstatements on the application form will void your Policy or be used to deny a claim for a loss incurred after the two

Misstatement of Age

If the age of the Policyholder has been misstated: 1) premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

Unpaid Premium

Any premium due and unpaid or covered by a note or written order may be deducted from any claim payment payable under this Policy.

Assignment

Under the terms of the contract with the PPO and Premier Dentists, payment is sent directly to the treating PPO or Premier Dentist. If the Eligible Person is treated by a Non-Contracted Provider, payment is sent to the patient and cannot be assigned elsewhere. Any such payments will discharge Us to the extent of payment made. Unless allowed by law, payments may not be attached, nor be subject to an Eligible Person's debts.

Refund of Unearned Premium

Upon your death, We will refund any unearned premium for this Policy on a pro-rata basis, less any claims paid during the current term of this Policy . We will make this refund within 30 days of receipt of due proof of Your death.

Conditions Under which KPIC or its Administrator Will Provide Benefits

Subject to the provisions of this Policy, KPIC or its Administrator agrees to notify the Insured in writing within the time frame required under this Policy if any services are denied coverage for Benefits, in whole or in part, stating the reason(s) for the denial.

If KPIC or its Administrator discovers that it has overpaid a provider for professional services, KPIC or its Administrator may notify the provider in writing through a separate notice identifying the overpayment amount.

Upon receipt of the notice, the provider must either reimburse KPIC or its Administrator or notify such entity in writing of any contested portion within thirty (30) days. If the provider contests the overpayment, it must identify the contested portion and specify the reason(s) for contesting.

Policyholder Responsibility for Fraud

The Policyholder must:

1. File accurate claims. If someone else, such as the Policyholder's spouse, Domestic Partner or another Dependent, files claims on Your behalf, You should review the form before You sign it;
2. Review the explanation of benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses incurred and the services rendered;
3. Never allow another person to seek medical treatment under Your identity. If Your ID Card is lost, You should report the loss to Us immediately; and
4. Provide complete and accurate information on claims forms and any other information forms. Attempt to answer all questions to the best of Your knowledge.

To maintain the integrity of Your plan, We encourage You to notify Us whenever a provider:

5. Bills You for services or treatments that You have never received;
6. Asks You to sign a blank claim form; or
7. Asks You to undergo tests that You feel are not needed.

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call Our toll-free hotline 1-800-835-2244. All calls are strictly confidential.

ELIGIBILITY AND ENROLLMENT

Policyholder Eligibility Provisions

This Policy describes the dental coverage, which is provided in conjunction with the health care coverage provided by Kaiser Permanente Insurance Company or Kaiser Foundation Health Plan under a health insurance coverage Policy issued between You and KPIC or between You and KFHP.

To be eligible for coverage under this Policy:

1) You must be covered under a health insurance policy issued by KPIC and/or KFHP; and
2) You are eligible to enroll in this plan on the first day of the month coinciding with your enrollment under KPIC's and/or KFHP's health insurance coverage; and
3) You remain enrolled under this Policy by paying the Premium due and are continually covered under KPIC's and/or KFHP's health insurance coverage; and
4) You meet the applicable Conditions of Eligibility as listed below.

Conditions of Eligibility

You shall have the option to enroll for coverage under the Policy under the following conditions:

1) You and Your Dependents may enroll only when first eligible or during an open enrollment period to be held not more than once annually.
2) If both spouses qualify as Policyholders, one spouse may enroll as a Dependent of the other spouse, but Dependent children may enroll for coverage under only one Policyholder and not both.
3) You shall agree to pay the monthly Premium.
4) You agree to remain enrolled for a minimum of twelve (12) consecutive months. If You discontinue coverage before reaching the twelve (12) months consecutive period, You shall not be allowed to re-enroll until the next annual open enrollment period.
5) If You elect to discontinue Dependent coverage, Dependents may not be re-enrolled under the Policy until the next annual open enrollment period, unless the Dependent is the subject of a Qualified Medical Child Support Order requiring the Policyholder to provide the Dependent benefits under the Policy.

Enrolling under this Policy

When You enroll for coverage under the Policy, You are enrolling for a period of one year. If You discontinue coverage before that year is up, You may not re-enroll until the next open enrollment period.

You and Your Dependent's enrollment under the Policy must parallel the enrollment in the KPIC and/or KFHP health insurance coverage. This means that if You enrolled Your dependents as Dependents under a KPIC and/or KFHP medical health insurance coverage, Your Dependents must be enrolled under this dental insurance plan.

Eligibility Provisions for Dependents

Eligible Dependents are the Policyholder's legal spouse or Domestic Partner and other Dependents from 19 to age 26. Dependent may include step-children, adopted children, children placed for adoption and foster children, provided they depend upon the Policyholder for support and maintenance.

A Dependent 26 years or older, may continue to be an Eligible Dependent even though not enrolled as a full-time student if they are incapable of self-support because of physical handicap or mental incapacity if that handicap or incapacity began before they reached age 26 and if they are chiefly dependent upon the Policyholder for support and maintenance. Proof of such handicap or incapacity and dependency must be submitted at least thirty-one (31) days prior to the dependent child attaining the limiting age of 26 years, and subsequently as may be required by KPIC or its Administrator. Neither KPIC nor its

Administrator will request such proof more frequently than annually after the child in question has reached age 26.

Continued Enrollment for Disabled Dependents age 26 and over

Such child will continue to qualify as a Dependent until the earlier of the following dates: a) the date the child recovers from the physically or mentally disabling sickness, injury or condition; or b) the date the child no longer chiefly depends on You for support and maintenance.

KPIC shall send a termination notice to the Policyholder at least 90 days prior to the date of the Dependent child's attainment of limiting age. KPIC shall require the Policyholder's submission of proof of such incapacity and dependency during the period commencing 60 days before and ending 60 days after the child's 26th birthday. Coverage will continue while KPIC is making a determination as to the child's eligibility for continued coverage.

Subsequently, proof of continued incapacity may be required by KPIC, but not more frequently than annually after the two-year period following the Dependent child's attainment of the limiting age. Proof of such incapacity and dependency must be submitted to KPIC within 60 days of KPIC's request

Dependents in military service are not eligible.

Every Policyholder and his/her respective dependents meeting the preceding conditions of eligibility are eligible for coverage under the Policy. However, KPIC or its Administrator will not provide Benefits for any Policyholder or his/her respective Dependents unless: (1) the Insured is included on the list Policyholder's submitted as required by this Section (or any revision or correction of such a list); (2) the Policyholder enrolls when first eligible or during an open enrollment period; and (3) the appropriate monthly Premium payment is made as required by this Policy.

A dependent's eligibility ends along with the Policyholder's eligibility, or sooner if the dependent loses his or her dependent status, unless Continued of Coverage is chosen in a timely fashion by or on behalf of the dependent(s) under the Continued Coverage Option section of this Policy. Eligibility for such continued coverage will continue for the period required by the Continuation of Coverage option. In any event, eligibility ends immediately when coverage under the Continuation of Coverage or under this Policy ends.

PREMIUMS AND POLICY TERMINATION

Your coverage provided under Your Insurance Policy may include coverage for Covered Services that are received from either Participating Dentists or non-Participating Dentists.

This section describes standards for appointment wait times and the availability of interpreter services when dental care is obtained from Participating Dentists

Appointment Wait Times
In accordance with the provisions of state law, access to dental care from a Participating Dentist will meet the following appointment availability standards:

1) Urgent dental care appointments shall be available within 48 hours of the request for appointment;
2) Non-urgent appointments for primary dental care shall be available within ten business days of the request for appointment;
3) Non-urgent appointments with Dental Specialists shall be available within fifteen business days of the request for appointment;
4) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other dental conditions shall be available within fifteen business days of the request for appointment; and,
5) Telephone triage, if any or screening services shall be provided in a timely manner appropriate for the Eligible Person's condition. The triage or screening waiting time shall not exceed 30 minutes.

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed Dentist, or the dental professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the Eligible Person's health.

Preventive care services, and periodic follow up care, including but not limited to, standing referrals to Dental Specialists for chronic conditions, laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed Dentist acting within the scope of his or her practice.

Notice of the Availability of Interpreter Services from a Participating Dentist
Language interpretation services in languages other than English are available to limited-English-proficient Eligible Persons at no cost and shall be coordinated with scheduled appointments for health care services from a Participating Dentist in a manner that ensures the provision of interpreter services at the time of the appointment without imposing an undue delay on the scheduling of the appointment. If You require interpreter services for Your Dental care appointment, please request such services at the time You call to schedule Your appointment.
This Policy shall remain in effect and renewable on each Policy Anniversary subject to the payment of premium and You continue to meet the eligibility requirements provided for under this Policy

PREMIUMS AND POLICY TERMINATION

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7) Non-urgent appointments for primary dental care shall be available within ten business days of the request for appointment;
8) Non-urgent appointments with Dental Specialists shall be available within fifteen business days of the request for appointment;
9) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other dental conditions shall be available within fifteen business days of the request for appointment; and,
10) Telephone triage, if any or screening services shall be provided in a timely manner appropriate for the Eligible Person's condition. The triage or screening waiting time shall not exceed 30 minutes.

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed Dentist, or the dental professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the Eligible Person's health.

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This Policy shall remain in effect and renewable on each Policy Anniversary subject to the payment of premium and You continue to meet the eligibility requirements provided for under this Policy

Premiums under this Policy are subject to change. To renew, just pay the premium due. It must be paid on or before the due date or within the grace period.

Premium Provisions

The first premium is due on the Policy Effective. Your subsequent premium is due on any premium due date. As long as this Policy remains in force, the premium for each month is due and payable on or before the last day of the preceding month. The premium will not change during any policy year, unless agreed to in writing between You and Us. The premium will be paid to KPIC through its Administrator and must be paid prior to the expiration of the Grace Period. A Grace period of 31 days is allowed.

KPIC reserves the right to change the premium on any Policy Anniversary, or at any time by written agreement between You and Us. We will give You 31 days advance written notice of any change in premium.

PREMIUMS AND POLICY TERMINATION

Grace Period

Premiums for each month are due and payable on or before the last day of the preceding month. The Policyholder has 31 days from each Premium due date (except the first) in which to pay the Premium then due. Your coverage under this Policy will stay in force during this grace period.

Coverage under this Policy will terminate if the premiums are not paid before or on the last day of the grace period. If You send KPIC written notice to terminate coverage under this Policy during the grace period, coverage will be terminated on the later of: (1) the date you requested; or (2) the first of the month following the date KPIC receives the notice. You must still pay KPIC all unpaid premiums, including a pro rata premium for coverage during the grace period.

Reinstatement

If any premium is not paid within the time granted to the Policyholder for payment, a subsequent acceptance of premium by us or by any agent duly authorized by the us to accept such premium, without requiring an application for reinstatement, shall reinstate the Policy ; provided, however, that if we or such agent require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects we and the Policyholder shall have the same rights as we had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed or attached thereon in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Rate Guarantee

The monthly premium as of the effective date of the Policy is: **On File**.

The rates by which the above premium was determined are not scheduled to change until the 1st day of the month following the 12-month anniversary of Policy effective date, unless this Policy effective date was the 1st of any month, in which case, any change in rates will be the 1st day of the Policy's 12th month anniversary.

Although rates are guaranteed as stated above, the monthly premium may change at any time due to changes in Your age, change in Your physical location.

Payment of Monthly Premium

The dental coverage described herein is not in effect until KPIC or its Administrator receives the Initial Premium from the Policyholder. The due date for subsequent Premium is the 10th day of each month. The Policyholder agrees to pay subsequent Premium no later than 31 days following the Premium due date, unless the Policyholder has given written notice requesting termination of dental coverage under the Policy in accordance with the Premiums and Policy Terminations section of this Policy. The Policyholder will be responsible for the payment of pro rata Premium for the time dental coverage under the Policy was in force during the 31-day grace period. Coverage for this Policy will commence on the Policy Effective Date set forth under this Policy. This Policy shall remain in effect subject to the payment of Premiums as required, and subject to the right of KPIC and the Policyholder to terminate in accordance with the terms of this Policy.
The following describes the termination provisions of this Policy.

Termination by KPIC

Coverage under this Policy will automatically terminate on the earliest to occur of the following dates:

PREMIUMS AND POLICY TERMINATION

1. If You fail to pay premiums in accordance with the provisions of this Policy, or KPIC does not receive premium payments in a timely manner, coverage will terminate effective on midnight of the last day of the 30-day Grace Period.
2. If You commit an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the Policy, KPIC may terminate this Policy by giving no less than 31 days written notice on any premium due date.
3. If You fail to comply with a material benefit plan contract provision, including eligibility rules, KPIC may terminate this Policy by giving no less than 31 days written notice on any premium due date.
4. If You cease to be eligible in accordance with the eligibility provisions of this Policy, coverage will be terminated for You and any Enrolled Dependents effective on midnight of the last day of the month in which loss of eligibility occurred.
5. Subject to the eligibility provisions of this Policy, if a Dependent ceases to be eligible according to the eligibility provisions of this Policy, coverage will be terminated only for that Dependent effective on midnight of the last day of the month in which loss of eligibility occurred.
6. On midnight of the last day of the month in which entry of the final decree of dissolution of marriage, annulment or termination of domestic partnership, a spouse or Domestic Partner shall cease to be an Eligible Dependent. Children of the spouse of the Domestic Partner who are not also the natural or legally adopted children of the Policyholder shall cease to be an Eligible Dependents at the same time.
7. If Your coverage under KPIC's or KFHP's medical insurance coverage ceases, coverage will terminate on midnight of the last day of the month in which Your eligibility ceases,

You will be liable for all unpaid premiums for the period during which the Policy was in force with respect to your terminated coverage.

Termination by You

You may terminate this Policy effective the first of any month by giving written notice to KPIC 31 days prior to the desired termination date. Termination will take effect on the later of the date stated in the Request for Termination notice or the first of the month following the date KPIC receives the notice.

Any Premium refund due will be reduced by the amount of claims paid after the coverage termination date. If claims paid after termination exceed the Premium refund, Employer shall reimburse KPIC for any overpayment.

If the Insured believes that this Policy, or coverage hereunder, has been terminated or not renewed due to his/her dental/health status or requirements for dental services, he/she may request a review by the Commissioner of the Department of Insurance of the state in which this Policy was issued.

If this Policy is terminated for any cause, KPIC or its Administrator is not required to predetermine services beyond the termination date or to pay for services provided after such termination date, except for the completion of Single Procedures begun while this Policy was in effect which are otherwise Benefits under this Policy.

Within 30 days after the end of this Policy, KPIC or its Administrator will return to the Policyholder any Premium paid which are applicable to a time period after the termination date, together with amounts due on claims, if any, less any amounts due to KPIC or its Administrator.

If KPIC accepts the proper amount of Premium, after termination of this Policy and without requiring a new application form, that acceptance will reinstate this Policy as though never terminated, unless KPIC or its Administrator, within five (5) business days after it receives such payment, either: (1) refunds the payment so made; or (2) issues a new Policy accompanied by written notice stating clearly those respects in which the new Policy differs from the terminated Policy in Benefits, coverage, or otherwise.

All Benefits end for the Policyholder and his/her covered Dependents when this Policy ends, and KPIC

will not provide continuation of Benefits to such persons in that event.

KPIC or its Administrator must notify the Policyholder in writing of any termination.

The validity of this Policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from the date of issue, and no statement made by any person covered under the Policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime unless it is contained in a written instrument signed by the person making such statement. Nothing in this Policy shall be construed in such a way as to prevent KPIC's Administrator from contesting, at any time, the eligibility of an Insured.

BENEFITS AND LIMITATIONS

I. Diagnostic and Preventive Benefits

Diagnostic:
- oral examinations
- x-rays
- diagnostic casts
- biopsy/tissue examinations
- specialist consultations

Preventive:
- prophylaxis treatments (cleanings)
- fluoride treatments
- space maintainers

Limitations on Diagnostic and Preventive Benefits:

1) KPIC will pay for oral examinations (except after hour exams and exams for observation), cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) and topical application of fluoride solutions no more than twice in an Accumulation Period, while the patient is an Insured under any KPIC dental insurance plans. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note: Periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit.

2) X-ray limitations:

   a) KPIC will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
   b) A complete intraoral series is limited to once every five (5) years.
   c) Bitewing x-rays are limited to two (2) times in each Accumulation Period when provided to Enrollees under 18 and one (1) time in each Accumulation Period for Enrollees 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

3) Topical application of fluoride solutions is limited to Enrollees to age 19.

4) Space maintainer limitations:

   a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee through age 14.
   b) Recementation of space maintainer is limited to once per lifetime.
   c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

5) Specialist Consultations, screenings of patients, and assessments of patients are limited to once in a lifetime per Provider and count toward the oral exam frequency.

II. Basic Benefits

Oral surgery:	Extractions and certain other surgical procedures, including pre- and post-operative care
Restorative:	Amalgam, synthetic porcelain and plastic 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 (root canal treatments)

BENEFITS AND LIMITATIONS

Periodontic:	Treatment of gums and bones supporting the teeth
Sealants:	Protective coating for posterior molar (back) teeth
Emergency palliative treatment	Palliative (emergency) treatment of dental pain — minor procedure

Limitations on Basic Benefits:

1) KPIC will not cover or replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

2) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

3) Root canal therapy and pupal therapy (resorbable filling) are not covered more than once in any five-year period. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

4) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth on one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

5) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

6) When allowed, retrograde fillings per root are limited to once in any 24-month period.

7) When allowed, root amputation per root and/or hemisection is limited to once in a lifetime.

8) Pin retention is covered not more than once in any 24-month period.

9) Palliative treatment is covered not more than three times in any six-month period, and the fee includes all treatment provided other than required x-rays or select diagnostic procedures.

10) Periodontal limitations:

    a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.
    b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planning.
    c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, or ridge augmentation.
    d) If in the same quadrant, scaling and root planing must be performed at least six weeks prior to the periodontal surgery.
    e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider.
    f) Periodontal cleanings Procedures Codes that include periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

11) Covered oral surgery services are covered once in a lifetime except removal of cysts and lesions and drainage procedures which are covered once in the same day.

12) Accession of tissue procedures and/or accession of exfoliative cytologic smears are allowed once in the same day. If more than one of these procedures is billed on the same day, for the same site, and by the same Provider/Provider office, KPIC will only pay for the most inclusive procedure.

13) The following oral surgery procedure is limited to age 19: transseptal fiberotomy/supra crestal fiberotomy, by report.

III. Crowns, Inlays, Onlays and Cast Restoration Benefits

Crowns, jackets, inlays, onlays and cast restorations will be covered when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.

Limitation on Crowns, Inlays, Onlays and Cast Restoration Benefits:
Crowns, inlays, onlays and cast restorations will be replaced only after five (5) years have elapsed following any prior provision under any of KPIC's dental insurance plans.

1) Crowns and onlays are limited to Enrollees age 12 and older and are covered not more than once in any five (5) year period except when KPIC determines the existing crown or onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experiences extensive loss or changes to tooth structure or supporting tissues.

2) When an alternate Benefit of an amalgam is allowed for inlays or porcelain/ceramic onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any five (5) year period.

3) Core buildup, including any pins, are covered not more than once in any five (5) year period.

4) Post and core services are covered not more than once in any five (5) year period.

5) Crown repairs are covered not more than once in any five (5) year period.

6) When allowed within six months of a restoration, the Benefit for a crown, inlay/onlay, or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

IV. Prosthodontic Benefits

Procedures for construction or repair of fixed bridges, partial or complete dentures.

Limitations on Prosthodontic Benefits:
See Table of Allowances for further reference.

Procedures for construction or repair of fixed bridges, partial or complete dentures.

Limitations on Prosthodontic Benefits:
See Table of Allowances for further reference.

1) Denture repairs are covered not more than once in any six-month period except for fixed denture repairs which are covered not more than once in any five (5) year period.

2) Prosthodontic appliances that were provided under any KPIC program will be replaced only after five (5) years have passed, except when KPIC determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Replacement of a prosthodontic appliance not provided under a KPIC program will be made if KPIC determines it is unsatisfactory and cannot be made satisfactory.

3) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

4) Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

5) KPIC limits payment for dentures to a standard partial or denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.

   a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a 12-month period and relining is limited to one (1) per arch in a six (6) month period.

   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.

6) Recementation of fixed partial dentures is limited to once in a lifetime

7) KPIC will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown, pontic or standard complete or partial denture toward the cost of the implant associated appliance i.e., the implant supported crown or denture. The implant appliance is not covered.

8) A labial veneer performed chairside is covered once in a 24-month period. A laboratory processed labial veneer is covered once every 5 years. Labial veneers are generally considered cosmetic services. A single labial veneer may be authorized if the tooth meets the criteria for a laboratory processed crown. If a veneer is allowed, a repair is considered included in the original fee for the first 24 months and denied thereafter.

V. Telehealth Services

1) Telehealth when used as a mode of delivering otherwise Covered Dental Services via interactive and non-interactive communications methods, including, email or the transmission of data via online technology, telephone and fax. Telehealth services are subject to the same cost share including deductible and annual or lifetime dollar maximum for the same services provided in-person.

NOTE: Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services.” Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

a) A composite restoration instead of an amalgam restoration on posterior teeth;
b) A crown where a filling would restore the tooth;
c) An inlay or porcelain/ceramic onlay instead of an amalgam restoration; or

d) Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown.

NOTE: Note on additional Benefits during pregnancy:

When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planning per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

GENERAL EXCLUSIONS

Services Not Covered (Exclusions)

1) Any treatment or procedure not listed as Covered Dental Services under the Benefits and Limitation section.
2) Charges in excess of the Usual, Customary and Reasonable fee, the Fee Actually Charged, or the amounts listed on the Table of Allowances, whichever is less.
3) Services received without cost from any federal, state or local agency, unless this is prohibited by law.
4) Services which are provided to the Insured by any Federal or State Governmental Agency or are provided without cost to the Insured by any municipality, county or other political subdivision, unless this exclusion is prohibited by law.
5) Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
6) Treatment to stabilize teeth, treatment to restore tooth structure lost from wear (abrasion, erosion), or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards and abfraction.
7) Any Single Procedure provided prior to the date the Enrollee became eligible for services under this dental plan.
8) Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
9) Experimental procedures.
10) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
11) Charges for anesthesia, except for general anesthesia administered by a licensed Provider in connection with covered oral surgery procedures.
12) Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
13) Services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis) their removal or other associated procedures.
14) Services for any disturbance of the temporomandibular (jaw) joints or associated Musculature, nerves and other tissues (TMJ).
15) Replacement of existing restoration for any purpose other than active tooth decay.
16) Intravenous sedation, occlusal guards and complete occlusal adjustment.
17) Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
18) Hypnosis.
19) Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
20) Charges for speech therapy.
21) Charges for lost or stolen appliances.
22) Services for which no charge is normally made in the absence of insurance.
23) Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broker appointments.
24) Orthodontic treatment.
25) Treatment plans that are more expensive than those customarily provided or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice.
26) Maxillofacial prosthetics.
27) Provisional and/or temporary restorations except an interim removable partial denture is covered only to replace extracted anterior permanent teeth during the healing period.
28) Cosmetic surgery or procedures for purely cosmetic reasons.
29) Laboratory processed crowns for Enrollees under age 12.
30) Fixed bridges and removable partials for Enrollees under age 16.
31) Interim implants.
32) Indirectly fabricated resin-based inlays and onlays.
33) Treatment by someone other than a Provider or a person who by law may work under a Provider's direct

supervision.

34) Services or supplies covered by any other health plan of the Contract holder.
35) Services provided by the dentist that does not have a clear and reasonable prognosis as a result of which the service(s) provided does not effectively treat the issue.
36) Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
37) Deductibles amounts over plan maximums and/or any service not covered under the dental plan.
38) Services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
39) Procedures not shown on the Table of Allowances

PREDETERMINATIONS

After an examination, Your dentist will talk to You about treatment You may need. The cost of treatment is something You may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, We encourage You to ask Your dentist to request a Predetermination.

A Predetermination does not guarantee payment. It is an estimate of the amount KPIC will pay if You are eligible and meet all the requirements of the Policy 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. KPIC will send Your dentist a Notice of Predetermination which estimates how much of the treatment costs We will pay and 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 KPIC.

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 charge.

CLAIMS PAYMENT AND APPEALS

All claims under this Policy is administered by:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

KPIC will pay a Participating Dentist directly for Covered Services performed by such Participating Dentist.

KPIC will pay the Insured directly for Covered Services provided by a non-Participating Dentist. Such payments are not assignable.

A claim for payment or reimbursement for the cost of Covered Services must be submitted to Us within 90 days after the day services were received. If You cannot submit it within that time, You must send it as soon as reasonably possible.

Claims must be filed on forms provided by or acceptable to Us. The forms may be obtained from and must be filed at Our Administrator's office at the address set forth above. If You ask for a Claim Form but do not receive it within 15-working days, You can file a claim without it by sending in the bills and describing the situation in a letter.

Claims will be acted upon within 30 working days of receipt. If a claim is denied in whole or in part, the written notice of denial will contain: (1) reasons for the denial; and (2) reference to pertinent provisions of the Policy on which the denial is based, and (3) information concerning the Insureds right of appeal.

If the denial of Benefits is due to a Participating Dentist failing to make a timely submission of claim, You shall not be liable to that Participating Dentist for the amount which would have been payable by Us, unless, You failed to advise them of Your eligibility at the time of treatment.

We will notify You in writing if Benefits are denied for any services, explaining the reason or reasons for denial. If You do not agree with the denial, You may ask for a review.

Payment for Services — Participating Dentist

Your payment for Covered Services performed for You by a Participating Dentist is calculated based on the Accepted Fee of the Participating Dentist less the amount in the Table of Allowances that is payable by KPIC.

Under this plan, seeing a Participating Dentist may reduce Your Out-of-Pocket Cost as Accepted Fees with Participating Dentists are typically lower than Usual, Customary and Reasonable (UCR) fee from non-Participating Dentists.

Payment for Services — non-Participating Dentist

Your payment for services performed for You by a non-Participating Dentist is calculated based on the Usual, Customary and Reasonable (UCR) fees less the amount in the Table of Allowances that is payable by KPIC.

You may be required to pay the non-Participating Dentist Yourself and then submit a claim to Us for reimbursement. Since Usual, Customary and Reasonable fees from non-Participating Dentists are higher than the Accepted Fee of Participating Dentists , Your Out-of-Pocket Cost may be significantly higher.

Complaint Procedure and Appeal of Denial

If You have any questions about the services You receive from a Participating Dentist, We recommend that You first discuss the matter with that Participating Dentist. If You continue to have concerns, call Our Administrator at 1-800-835-2244.

If You are dissatisfied with the results of a review, You may request reconsideration. Your request must be in writing and filed with Our Administrator at the address set forth above. Your written request for reconsideration must be filed within 180 days after the notice of denial is received. A written decision will be issued within 30 days after Our Administrator receives the request for reconsideration, unless You are notified that additional time is

required, but in no event later than 120 days from the time Our Administrator receives the request.

Payment of Benefits

Benefits will be payable as they accrue and any balance remaining unpaid at termination of the period of liability will be paid immediately upon receipt of due written proof of loss. However, unless You direct otherwise in writing, Our Administrator has the option of paying all or part of such Benefits directly to a person or institution on whose charges claim is based.

Most dental offices have standard Claim Forms available. Participating Dentists will fill out and submit Your claims paperwork for You. Some non-Participating Dentists may also provide this service upon Your request. If You receive services from a non-Participating Dentist who does not provide this service, You can submit Your own claim directly to Us or Our Administrator.

Under the terms of the contract with a-Participating Dentist, payment is sent directly to the treating Participating Dentist. If the Insured is treated by a non-Participating Dentist, payment is sent to the patient and cannot be assigned elsewhere. Any such payments will discharge Us to the extent of payment made. Unless allowed by law, payments may not be attached, nor be subject to an Insured's debts.

Payments by Us for any Single Procedure that is a Covered Service will be made upon completion of the procedure. Payment for care is applied to the Deductible and Maximum Benefit based on the date of service, regardless of when the claim is submitted. After You have satisfied Your Deductible requirement, We will provide payment for Covered Services up to a Maximum Benefit for each Insured in each Accumulation Period.

Time Limitations

If any time limitation provided in this Policy for giving notice of claims, or for bringing any action at law or in equity, is less than that permitted by the applicable law, the time limitation provided in the Policy is extended to conform with the minimum permitted by the applicable law.

Money Payable

All sums payable by or to KPIC or its Administrator must be paid in the lawful currency of the United States.

The Appeals Process

Benefits, unless otherwise provided in this Policy, are available from the Eligibility Date of the Insured.

An Insured may choose the services of any licensed Dentist, but neither KPIC nor its Administrator guarantees the availability of any particular Dentist.

Before KPIC is obligated to approve and/or satisfy any claims under this Policy or the Policy under which this Policy is issued, KPIC or its Administrator is entitled to receive, to such extent as is lawful, such information and records relating to attendance to, or examination of, or treatment provided to an Insured from any attending or examining Dentist or from hospitals in which a Dentist's care is provided, as may be required in the administration of such claims; or to require that an Insured be examined by a dental consultant retained by and paid for by KPIC or its Administrator in or near his or her community or residence. KPIC and its Administrator agrees in every case to hold such information and records as confidential.

CONTRACTS BETWEEN KPIC or KPIC'S ADMINISTRATOR AND ITS PARTICIPATING DENTISTS PROVIDE THAT, IN THE EVENT KPIC OR KPIC'S ADMINISTRATOR FAILS TO PAY THE DENTIST, THE INSURED WILL NOT OWE THE DENTIST FOR ANY SUMS OWED BY KPIC OR KPIC'S ADMINISTRATOR.

KPIC will pay the Insured directly for services provided by a Dentist who is non -Participating Dentist, and those payments are not assignable.

Written notice of the occurrence or commencement of Covered Services, treatment and supplies must be provided to KPIC within 20 days after such loss, or as soon as is reasonably possible. Written proof of such loss must be provided to KPIC within 90 days after such loss. Failure to provide such proof shall neither invalidate nor

reduce any claim if it is not reasonably possible to furnish such proof within such time, provided such proof is provided as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required

KPIC will give each Dentist, or Insureds, not later than 15 days after such request, a standard form to make a claim for payment for services covered by this Policy. In order to make a claim for payment, such form (completed by the Dentist who provided the services and by the Insured or the patient's parent or guardian if such patient is a minor) must be submitted to KPIC's Administrator at the address on the form.

If KPIC fails to provide a claim form within 15 days after such request, the person making such claim will be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed above, written proof covering the occurrence, character and extent of the loss for which claim is made.

Benefits payable under the Policy shall be paid within 30 days of receipt of written proof of loss. No action in law or in equity shall be brought on the Policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Policy, and no such action shall be brought at all unless brought within three years from the expiration of time within which proof of loss is required under the Policy.

KPIC agrees to notify the Insured if any services submitted on a claim under the preceding paragraph are denied coverage as Benefits, in whole or in part, stating the reason(s) for the denial. Within sixty (60) days after receipt of such notice, the Insured may make a written request for review of such denial. Such request for review must be addressed to KPIC's Administrator, PO Box 997330, Sacramento, California 95899-7330, Telephone [(888) 335-8227, Attention: Benefit Services Department. Such request for review must state the reason(s) why the Insured believes that the denial of the claim was in error and must request any pertinent documents which they wish to review. The Benefit Services Department of KPIC's

Administrator will make a full and fair review of the claim. KPIC's Administrator agrees to provide a decision on a request for review to the Insured in writing within 120 days after KPIC's Administrator receives the request for review.

CLAIMS DISPUTE IMPORTANT NOTICE

Important Notice

If You have an insurance complaint, You may contact KPIC by writing to the address below:

You may contact KPIC at:

Kaiser Permanente Insurance Company
One Kaiser Plaza, 25B
Oakland CA 94612

Or by calling KPIC's Administrator at 1-800-835-2244

If the dispute is not resolved or if You have **an** insurance complaint that cannot be satisfactorily resolved through a discussion or correspondence with KPIC, You may contact the California Department of Insurance, at:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

For callers outside California and California area codes
(213) and (310), call (213) 897-8921

For California callers in all other area codes, call (800) 927-4357
TDD: 1-800-482-4TDD
(1-800-482-4833)
Electronically:
www.insurance.ca.gov

Who Can Answer Your Questions?

For assistance with questions regarding Your coverage, such as Your benefits, Your current eligibility status, or name and address changes, please have your ID card available when You call:

Customer Services Department
1(800)-835-2244
Or You may write to:

Delta Dental of California our Administrator:
P.O. Box 997330
Sacramento. CA 95899

Or You may contact our Administrator, Delta Dental on the Internet at:

www.deltadentalins.com

OTHER OBLIGATIONS OF KPIC ADMINISTRATOR

This Policy is Administered by:

Delta Dental of California
PO Box 997330
Sacramento, CA 95899-7330

KPIC's Administrator shall encourage Participating Dentists to submit a standardized Attending Dentist's Statement (ADS) before providing service, showing the patient's dental needs and the treatment necessary in the professional judgment of the Dentist.

KPIC's Administrator shall predetermine, from the ADS and other data, what would be payable by KPIC's Administrator and an Insured for the proposed services under the terms of this plan as of the date of Predetermination.

Such Predetermination shall not constitute a guaranty or authorization of Benefits under this Policy, and any actual payment by KPIC's Administrator will depend on the patient's eligibility and remaining annual maximum when completed services are reported to KPIC's Administrator.

KPIC's Administrator shall advise Participating Dentists to notify the patient of all information provided by KPIC's Administrator in the Predetermination.

A Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an Insured . KPIC's Administrator will predetermine the amount of Benefits payable under this Policy for the listed services. Predeterminations are valid for sixty (60) days from the date of the Predetermination but no longer than this Policy's term nor beyond the date the patient's eligibility ends.

KPIC's Administrator will not make any payment for services provided to a patient who is not an Insured under the Policy when the service is provided.

KPIC's Administrator will provide professional review of the adequacy of service provided by Participating Dentists.

KPIC's Administrator agrees to furnish to the Insured on his/her Effective Date and at reasonable times thereafter, a directory of Participating Dentists who have agreed to provide the services described in this Policy. It is understood that the Dentists listed in that directory may change from time to time and KPIC's Administrator reserves the right to update the directory without prior notice to the Insured. However, KPIC's Administrator agrees to give notice to the Insured within a reasonable time of any Participating Dentist's termination or breach of contract, or inability to perform, which will materially and adversely affect the Insured. Current information concerning the Participating Dentist status of any Dentist may be obtained by telephoning KPIC's Administrator Membership and Fee Listing Department at 1-800-835-2244 or by visiting www.deltadentalins.com. The Dentists providing or contracting to provide dental services under this Policy are solely responsible for those dental services, and in no case will KPIC or its Administrator or Insureds be liable for any act or omission by such Dentists and/or their agents.

COORDINATION OF BENEFITS

Coordination of Dental Plan Benefits

If any Covered Services under this Policy are also payable under health or other dental insurance or other health coverage, We will not make payment under this dental Policy until after We determine what benefits are paid or payable by the health insurance or other dental or health coverage plan. This coordination of benefits (COB) provision applies when a person has health or dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below. The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all Coverage Plans do not exceed 100% of the total allowable expense. When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

a) The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.
b) A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.
c) Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
d) The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1) Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.
2) Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Coverage Plan is:
    e) The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
        - The parents are married;
        - The parents are not separated (whether or not they ever have been married); or
        - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
    f) b. If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.
    g) c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
3) The Coverage Plan of the custodial parent;
4) The Coverage Plan of the spouse or Domestic Partner of the custodial parent;
5) The Coverage Plan of the noncustodial parent; and then
6) The Coverage Plan of the spouse or Domestic Partner of the noncustodial parent.

As used above, “Coverage Plan” were a contract or insurance policy which provides coverage for dental care services.

Right to Receive and Release Needed Information

COORDINATION OF BENEFITS

Certain facts are needed to apply these COB rules. KPIC Dental has the right to decide which facts it needs. It may get needed facts from, or give them to, any other organization or person. KPIC Dental need not tell or get the consent of any person to do this. Each person claiming benefits under this plan must give KPIC Dental any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this Policy. If it does, KPIC may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under this Policy. KPIC will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by (insurer) is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of:

A. The person it has paid or for whom it has paid;
B. Insurance companies; or
C. Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

Subrogation will not be allowed in any plan as distinguished from the rights to recovery.

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CONTINUED COVERAGE OPTION

For purposes of this Option, the following are "Qualifying Events":

a. Death of the Insured;

b. Divorce or legal separation from the Insured;

c. The Insured becoming entitled to Medicare benefits;

d. A dependent child ceasing to meet the description of dependent child; and/or

e. A Federal Chapter 11 bankruptcy proceeding which (within one year before or one year after the filing) causes a substantial elimination of coverage of the Insured.

Eligible Dependents whose coverage under this plan ends due to Qualifying Events “a”, “b”, “c”, or “d”, may choose to continue their coverage for thirty-six (36) months following the month in which the Qualifying Event occurs.

An Eligible Person whose coverage under this plan ends due to Qualifying Event “e” may choose to continue their coverage until death (in the case of an Eligible Person), or for thirty-six (36) months after the date of death of the Eligible Person (in the case of Eligible Dependents).

Continued coverage can be chosen only by notice to KPIC’s Administrator which must be given no later than sixty (60) days after a termination of coverage by reason of a Qualifying Event, or within sixty (60) days after the Insured receives a notice from KPIC’s Administrator about his or her rights to continued coverage because of the particular Qualifying Event, whichever is later. Persons for whom a Qualifying Event described in b or d occurs must report it to KPIC’s Administrator within sixty (60) days, or lose their right to choose continued coverage.

Continued coverage chosen by a person under this Section is effective on the first day of the month following the applicable Qualifying Event described above. However, Benefits are not available to a person choosing continuing coverage until KPIC’s Administrator receives the data about such person as required hereunder, along with all Premium then due for such person. KPIC’s Administrator will not, in any event, make Benefits available hereunder with respect to any person for whom KPIC’s Administrator does not receive such information and Premium within sixty (60) days after the date such person is required under this Option to notify KPIC’s Administrator of his or her election.

Continued coverage will be the same as the coverage for similarly situated Insureds under this Policy, and if coverage is modified for such Insureds, coverage for persons having continued coverage will be modified at the same time and in the same manner.

A person's continued coverage chosen under this Section will end on the last day of the month in which any of the following events first occurs:

f. The period of continued coverage specified above ends.
g. This Policy ends.
h. Insured fails to pay Premium for the person as required by this Policy.
i. The person with continued coverage becomes covered for dental Benefits under another health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such person covered under this plan.
j. The person becomes eligible for Medicare benefits.

Once continued coverage under this Option ends, it cannot be reinstated.

INDEPENDENT MEDICAL REVIEW

Your Right to an Independent Medical Review

If You believe that health care services have been improperly denied, modified, or delayed, You may have the right to an independent medical review. For more information about how to obtain this review, please call KPIC toll free number at 1-800-392-8649.

Experimental or Investigational Therapy

You may also have the right to an independent medical review upon the concurrence of the following:

1. You have a Life-threatening or Seriously Debilitating Condition;
2. Duly certified by Your Physician, for which:
   a) standard therapies have not been effective in improving Your condition; or
   b) standard therapies would not be Medically Necessary; or
   c) there is other beneficial therapy covered under this Policy other than the proposed experimental or investigational therapy; and
3. Your contracting Physician has recommended a drug, device, procedure or therapy duly certified by him in writing that it is likely to be more beneficial than any available standard therapy; or You or Your Physician duly licensed and board certified to practice in the area of practice appropriate for Your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial to You than any other available therapy.
4. The Physician's certification shall contain a statement of the evidence relied upon by him in making the above recommendation;
5. Such recommendation or request as stated in item number 3 above has been denied, delayed or modified by us based on Medical Necessity; and
6. The therapy, drug, device or procedure would otherwise be covered under the Policy were it not determined by us that such therapy, drug, device or procedure is experimental or investigational.

Upon denial of coverage as stated in item number 4, a notice shall be sent to You, explaining in detail Your rights under this process.

"Life-threatening" means either or both of the following:

1. Sickness or Injury where the likelihood of death is high unless the course of the Sickness is interrupted.
2. Sickness or Injury with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Seriously Debilitating Condition" means Sickness or Injury that causes major irreversible morbidity.

GENERAL DEFINITIONS

The following terms have special meaning throughout the Policy. Certain words that You will see in this Policy have specific meanings. These definitions should make Your dental insurance plan easier to understand.

Administrator means Delta Dental of California (Delta Dental), P.O. Box 997330, Sacramento, CA 95899. KPIC reserves the right to change the Administrator at any time during the term of the Policy without prior written notice.

Accepted Fee means the fee for each Single Procedure that a Participating Dentist has contractually agreed to accept as payment in full for treating an Insured Person. A Covered Person will not be liable to pay more than the Accepted Fee.

Annual Deductible - the amount You must pay for dental care each year before the Policy Benefits begin.

Attending Dentist's Statement (ADS) - a form used by Your dentist to request payment for dental treatment or Predetermination for proposed dental treatment.

Benefits – the dental services covered under the Policy and described in this Policy.

Categories of benefits:

Diagnostic - procedures to help the dentist evaluate Your dental health to determine necessary treatment.

Preventive - procedures to prevent dental disease (cleanings, for example).

Basic - procedures necessary to restore the teeth (other than crowns or cast restorations), oral surgery, endodontic (root canals) and periodontic (gum) procedures.

Crowns and cast restorations - caps, veneers, inlays and onlays.

Prosthodontic - procedures involving bridges and dentures to replace missing teeth.

Covered Services - those dental Benefits to which benefit payment will be applied, according to the Table of Allowances.

Dependent means only: a) Your spouse or Domestic Partner; and b) Your, Your spouse's, or Domestic Partner's child who is of an age within the age limits for Dependent children shown in the Table of Allowances The word **"child"** includes: a) Your step-child; b) the child of Your son or daughter if Your son or daughter is an insured Dependent under the Policy; c) the child of Your domestic partner; and d) any other child who lives with You and for whom You or Your Domestic Partner are the legal guardian. A child shall be deemed to be a Dependent of not more than one person. Other types of dependents eligible for coverage, if any, are shown in the Table of Allowances.

You must notify us immediately upon any Dependent changes, including the termination of a domestic partnership.

Domestic Partner means an adult in a domestic partnership . A Domestic Partner, as defined under the California Family Code applicable state law maybe regarded as your dependent. A Domestic Partner may be regarded as your Dependent if: a) the domestic partnership meets all of the domestic partnership requirements under California law, or was validly formed in another jurisdiction; or b) the domestic partnership is in accord with Your eligibility requirements, if any, that are less restrictive than California law. Rules pertaining to domestic partnership shall be governed by the provisions of the California Family Code.

GENERAL DEFINITIONS

Effective Date - the date Your coverage under the Policy starts.

Eligible Dependent - any of the Insured's dependents who are eligible to enroll for benefits in accordance with the eligibility provisions outlined in this Policy.

Eligible Person – an enrolled individual or a dependent who meets the conditions of eligibility outlined in this Policy, or a person ceasing to meet such conditions who elects continued coverage as provided in this Policy, and for whom the appropriate monthly payment is received by KPIC or its Administrator.

Explanation of Benefits (EOB) - a summary of covered expenses KPIC or its Administrator will send to You after Your dentist files a claim.

Insured means a Policyholder and/or a Dependent of a Policyholder duly enrolled under this Policy.

Maximum - the greatest dollar amount KPIC will pay for covered dental services in any calendar year.

Participating Dentist - a dentist who has a signed agreement with KPIC or its Administrator. These dentists have filed their Usual fees, which have been accepted by KPIC or its Administrator as Customary and Reasonable. They agree to charge this dental insurance plan's patients these Accepted Fees. Participating Dentists are the Delta dental PPO Dentists and Delta Dental Premier Dentists.

Policyholder means an individual noted as Policyholder in this Policy who conforms to the administrative and other provisions established under this Policy.

Predetermination - a pre-treatment estimate KPIC or its Administrator makes upon request of Your dentist, detailing what the plan will pay for a proposed treatment, and what Your responsibility will be.

Premium - the money paid each month for You and Your Dependents' dental coverage.

Single Procedure - a dental procedure to which KPIC or its Administrator has assigned a separate procedure number; for example, a three-surface amalgam restoration of one permanent tooth or a complete upper denture, including adjustments for a six-month period following installation.

Table of Allowances - the list of amounts KPIC will pay for each covered dental service.

Usual, Customary and Reasonable (UCR):

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

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

A ***REASONABLE*** fee can be Usual and Customary, or KPIC or its Administrator may agree that a fee that falls above Customary, is justified by a superior level or complexity (difficulty) of treatment than that customarily provided.

GENERAL DEFINITIONS

IMPORTANT: If You opt to receive dental services that are not covered services under this policy, a participating provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, You may call KPIC or it's Administrator Delta Dental at 1(800)-835-2244. To fully understand your coverage, you may wish to carefully review this evidence of coverage docum