KAISER PERMANENTE
Kaiser Permanente Insurance Company

Kaiser Permanente Insurance Company
Participating Provider Organization (PPO)
Dental Insurance Plan

Certificate of Insurance

Policyholder:

Address:

Group Dental Policy Number:

Group Dental Policy Effective Date:

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, California 94612

GROUP DENTAL CERTIFICATE

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).

This Certificate of Insurance (Certificate) describes Benefit coverages funded through a Group Insurance Policy (Group Policy) issued to Your group by Kaiser Permanente Insurance Company. It becomes Your Certificate when You have met certain eligibility requirements.

This Certificate is not an insurance policy. The complete terms of the coverage are set forth in the Group Policy. Benefit payment is governed by all the terms, conditions and limitations of the Group Policy. If the Group Policy and this Certificate differ, the Group Policy will govern. The Group Policy and this Certificate are governed by the laws of the state in which the Group Policy was delivered. The Group Policy is available for inspection at the Policyholder's office.

This Certificate was issued on the basis that the information on Your enrollment form was correct and complete. If any information on the enrollment form was not correct or complete, write to KPIC's Administrator within ten days of receipt of this Certificate. An error or omission may result in loss of coverage as of Your Effective Date.

This Certificate supersedes and replaces any and all certificates that may have been previously issued to You for the coverage described herein.

In this Certificate, Kaiser Permanente Insurance Company will be referred to as: "KPIC", "We", "Us", or "Our." The Covered Person named in the attached Schedule of Coverage will be referred to as: "You" or "Your."

This Certificate is important to You and Your family. Please read this Certificate carefully and keep it in a safe place.

Please refer to the General Exclusions and Limitations section of this Certificate for a description of this plan's general exclusions and limitations. Likewise, the Schedule of Coverage contains specific limitations for specific Benefits.

If You require this Certificate, 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 this Certificate is the official version. The foreign language version is for informational purposes only.

TABLE OF CONTENTS

The Sections of this Certificate appear in the order set forth below.

Introduction

*Schedule of Coverage**

General Definitions

Eligibility, Effective Date, and Termination Date

Timely Access To Care

Pre-Treatment Estimate

Selecting Your Provider

General Benefits and Limitations

General Exclusions and Limitations

General Provisions

Coordination of Benefits

Claim Provisions

Claims Dispute Important Notice

ERISA Claims and Appeals Procedures

Continuation of Coverage

**Included with this Certificate. Please consult with Your group Administrator if the Schedule of Coverage was not included when this Certificate was issued to You.*

INTRODUCTION

How To Use This Certificate

This Certificate includes a Schedule of Coverage that will give You a quick overview of Your coverage. It is very important, however, that You read this entire Certificate.

This Certificate uses many terms that have very specific definitions for the purpose of this plan. These terms are capitalized so that You can easily recognize them and are defined in the General Definitions section. Other parts of this Certificate may contain definitions specific to those provisions. Terms that are used only within one section may be defined only in those sections. Please read these definitions carefully.

Introduction To Your Plan

Please read the following information carefully. It will help You understand how the Provider You select can affect the dollar amount You must pay.

Under this Policy, Covered Dental Services can be provided by a Contracted Providers/Dentists or any licensed Dentist. If you go to a Contracted Provider/Dentist your out-of-pocket expense may be less because Contracted Providers have agreed to charge lower fees than usually charged in their offices. Additionally, between the PPO Dentists and Premier Dentists who are both Contracted Providers/Dentists, your out of pocket is less if you go to a PPO Dentist.

For a more detailed explanation about the basic differences in Your Out-of-Pocket Costs, please - refer to the **Selecting Your Provider** section of this Certificate.

Delta Dental of California (Delta Dental) is KPIC's Administrator for this Certificate. Likewise, KPIC has contracted with Delta Dental for the use of its Network of Contracted Providers, PPO Dentists and Premier Dentists. These Dentists are referred to under this Certificate as Contracted Providers.

KPIC is not responsible for Your decision to receive treatment or services from Non-Contracted Providers nor is KPIC liable for the qualifications of Providers for treatments or services provided.

For a directory of Contracted Providers please call 1-800-835-2244 or visit KPIC's Network of Contracted Providers at: www.deltadentalins.com.

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:

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

GENERAL DEFINITIONS

The following terms have special meaning throughout this Certificate. Other parts of this Certificate may contain definitions specific to those provisions. Terms that are used only within one section of this Certificate are defined in those sections.

Accepted Fee means the fee for each Single Procedure that a Contracted Provider has contractually agreed to accept as payment in full for treating a Covered Person. A Covered Person will not be liable to pay more than the Accepted Fee. Also referred to as "PPO Provider's Contracted Fee."

Accumulation Period means: 1) a period of time that is available to the Covered Person to satisfy the Deductible or Benefit Maximum of the Group Policy; or 2) a period of time applicable to the plan maximums, if any, under the Group Policy, such as visit, day and dollar limits. Accumulation Period may either be Calendar Year or Policy Year. The Accumulation Period is set forth in the Schedule of Coverage.

Administrator means Delta Dental of California (Delta Dental), P.O. Box 997330, Sacramento, CA 94105. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior written notice.

Benefits mean those Covered Services which are made available to Covered Persons under the terms of the Group Policy and which are listed as part of this Certificate.

Benefit Maximum means the total maximum dollar amount the Group Policy will pay for Covered Services toward the cost of dental care incurred by an individual Covered Person in an Accumulation Period.

Calendar Year means a period of time: 1) beginning at 12:01 a.m. on January 1st of any year; and 2) terminating at midnight on December 31st of that same year.

Claim Form means a written or electronically submitted document to request payment for completed dental treatment or to request a Pre-treatment Estimate for proposed dental treatment. Claim forms are also called "Attending Dentist's Statement."

Coinsurance means the Covered Person's share of the cost of a given service, usually expressed as a percentage of the owed amount.

Contracted Provider means a dentist who is a PPO or Premier Dentist and contracted to participate in the Delta Dental PPO and Premier network Deductible specified in the Schedule of Coverage.

Dependent means only: a) Your spouse or Domestic Partner (if eligible under this plan); and b) Your or Your spouse's child who is of an age within the age limits for Dependent children shown in the Schedule of Coverage. 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 Group 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 Schedule of Coverage.

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 may be regarded as Your Dependent if:

a) the domestic partnership meets all of the domestic partnership requirements as defined in Section 297 of the California Family Code, or was validly formed in another jurisdiction; or

b) the domestic partnership is in accord with Your Group's eligibility requirements, if any, that are less restrictive than California law.

Effective Date means the date coverage under the Group Policy becomes effective. The Effective Date for this Certificate is shown on the face page of the Group Policy. Your Effective Date and that of Your enrolled Dependents (if any), will be governed by the Eligibility and Enrollment rules set forth in this Certificate.

Eligible Employee means an employee of the Policyholder and duly certified by such Policyholder as one eligible to enroll under the terms of the Group Policy. An Eligible Employee includes an employee entitled to coverage under a trust agreement. An Eligible Employee may also include a Retiree as defined herein.

Emergency Dental Condition means dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, it could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part, or
- death

Emergency Dental Service means a dental screening, examination and evaluation by a Dentist or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

Expense(s) Incurred means expenses a Covered Person incurs for Covered Services. An expense is deemed incurred as of the date of the service or treatment received.

Explanation of Benefits (EOB) see definition of **Notice of Payment.**

Generally Accepted Dental Practice Standards means treatment that is consistent with sound, professionally recognized dental standards of practice as determined by the treating licensed Dentist acting within the scope of their practice in California for the dental condition in question.

Insured Employee means a Covered Person who is an Eligible Employee of the Policyholder or an Eligible Employee entitled to coverage under a trust agreement. Also referred to as an "Enrollee."

Maximum Contract Allowance means the maximum amount that KPIC pays for Covered Services.

For purposes of this Certificate, the Maximum Contract Allowance is as follows:

1) For a PPO Dentist, it is the lesser of:
    a. the Accepted Fee of the PPO Dentist; or
    b. the Submitted Amount.

2) For a Premier Dentist, it is the lesser of:
    a. the Accepted Fee of the PPO Dentist for a PPO General Dentist in the same geographic area; or
    b. the Submitted Amount.

    For Covered Services received from a Premier Dentist, the Covered Person will be responsible for the payment of any amount in excess of the Maximum Contract Allowance but not more than the Accepted Fee of the Premier Dentist.

    For purposes of this definition the *Accepted Fee of the PPO Dentist for a PPO General Dentist in the same geographic area* is the default fee **as basis for the Maximum Contract Allowance** for a non-special (general dentist) provider in that region.

3) For a Non-Contracted Provider, it is the lesser of:
   a. the Accepted Fee of the PPO Dentist for a PPO General Dentist in the same geographic area; or
   b. the Submitted Amount.

   For Covered Services received from a Non-Contracted Provider, the Covered Person will be responsible for the payment of any amount in excess of the Maximum Contract Allowance but not more than the Submitted Amount from the Non-Contracted Provider.

   For purposes of this definition the *Accepted Fee of the PPO Dentist for a PPO General Dentist in the same geographic area* is the default fee **as basis for the Maximum Contract Allowance** for a non-special (general dentist) provider in that region.

Medicare Eligible means: 1) a person who is eligible or entitled for coverage under Medicare Part A or Medicare Part B, or both, either by virtue of age or disability; 2) and is covered for dental insurance under the Group Policy in accordance with the Policyholder's retirement or employment policy.

Network means a collective expression for all Delta Dental Dentists who have contracted with Delta Dental to offer Covered Services to Covered Persons. There are two (2) separate and distinct Delta Dental Networks: 1) Delta Dental PPO™; and 2) Delta Dental Premier®. Visiting a PPO Dentist generally gives You the lowest Out-of-Pocket Cost. For a list of Delta Dental Network Dentists visit www.deltadentalins.com.

Non-Contracted Providers means a Dentist who is neither a PPO nor a Premier Dentist and is not contracted to participate in the Delta Dental Network and will bill You directly for the actual charges.

For Covered Services received from a Non-Contracted Provider, the Covered Person will be responsible for the payment of any amount in excess of the Maximum Contract Allowance but not more than the Submitted Amount from the Non-Contracted Provider.

Notice of Payment (also called Explanation of Benefits or "EOB") means the statement You receive after services have been provided and a claim processed. The EOB details how Your claim payment was calculated including the procedures performed, Submitted Fee(s), Maximum Contracted Allowance and the amount for which You are responsible. Also referred to as "Your dental benefits statement."

Out-of-Pocket Costs means the portion of dental fees that You pay. Out-of-Pocket Costs include Your Deductible, Coinsurance, any amount exceeding the Calendar Year Maximum Benefit, any amount exceeding the Maximum Contract Allowance, and charges for optional services, if any, that are not covered by the Group Policy.

Participating Provider Dentist (PPO Dentist) means a Dentist who contracts with the Delta Dental Network and agrees to accept the PPO Maximum Contract Allowance as payment in full for Covered Services provided to a Covered Person

Percentage Payable means the percentage of Covered Services to be paid by KPIC. The Percentage Payable is applied against the Maximum Contract Allowance.

Policy Year means a period of time: 1) beginning with this plan's Effective Date of any year; and

2) terminating on the same date. If this plan's Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

Policyholder means the employer, trust or other entity noted on the Group Policy as the Policyholder who conforms to the administrative and other provisions established under the Group Policy.

PPO Provider's Contracted Fee means the fee for each Single Procedure that a Contracted Provider has contractually agreed to accept as payment in full for treating a Covered Person. A Covered

Person will not be liable to pay more than the Accepted Fee. Also referred to as “Accepted Fee”

Premier Dentist means a Dentist who contracts with the Delta Dental Network and agrees to accept the Premier Maximum Allowance as payment in full for Covered Services provided to a Covered Person.

For Covered Services received from Premier Dentists, the Covered Person will be responsible for the payment of any amount in excess of the Maximum Contract Allowance but not more than the Accepted Fee of the Premier Dentist.

Premiums means the money paid to KPIC each month for Your and Your Dependent’s dental coverage.

Pre-treatment Estimate means a non-binding estimate of allowable Benefits under a Covered Person’s plan for services proposed. The Pre-treatment Estimates includes the Enrollee’s Out-of-Pocket Cost.

Provider means a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or a dental clinic. Also referred to as a “Dentist."

Retiree means a former employee of the Policyholder who: 1) is no longer engaged as an active employee of the Policyholder or is not a working aged under the Working Aged Provisions (TEFRA/DEFRA) of the federal law; and 2) meets the Policyholder’s eligibility requirements to receive Benefits under the Group Policy. Retiree may also include a Medicare Eligible employee.

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

Submitted Amount means the amount the dental office bills and enters on the Claim Form for a specific procedure. Also referred to as “Submitted Fee.” This is generally the actual charges billed by the Dentist for Covered Services.

Urgent Dental Services means medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Eligibility for Coverage

The following persons will be eligible for insurance:

All Eligible Employees and Dependents of Eligible Employees are eligible to enroll in this plan.

If You chose to enroll a Dependent and have more than one eligible Dependent You must enroll all eligible Dependents in this plan.

Eligible Employees Eligibility Date

Your eligibility date is the date Your employer becomes a Policyholder if You are an Eligible Employee on that date, and the Policyholder's Application for coverage indicates that the eligibility waiting period (if any) does not apply to initial employees. Otherwise, Your eligibility date is the first day of the calendar month coinciding with or next following the date You complete the eligibility waiting period elected by the Policyholder.

Effective Date of Your Insurance

Your Effective Date of insurance is determined from the Enrollment Rules that follow.

Enrollment Rules

1. Timely Enrollment. If You enroll during the 31-day period that follows Your eligibility date, Your Effective Date is the first day of the calendar month coinciding with or next following Your eligibility date.
2. Late Enrollment. If You enroll for coverage more than 31 days after Your initial eligibility date, You will be considered a Late Enrollee. Late Enrollees are eligible for enrollment only during the annual open enrollment period set by the Policyholder. If You enroll during this period, Your Effective Date is the date agreed upon between the Policyholder and KPIC.
3. Annual Open Enrollment. If You enroll on or before Your eligibility date, Your Effective Date is the date agreed upon between the Policyholder and KPIC.

You are not eligible if You are not in Active Service on the date coverage would otherwise become effective. Coverage resumes on the first day of the month after You return to Active Service and Premiums have been paid.

Active Service means an employee of the Policyholder who is: 1) present at work with the intent and ability to work the scheduled hours; and 2) performs in the customary manner all of the duties of his or her employment for a period of at least 20 hours per week. Active Service does not include a person engaged in seasonal employment.

Termination of an Eligible Employee's Insurance

Your insurance will terminate on the earlier of the following dates:

1. The date the Eligible Employee ceases to be covered under a Kaiser HMO or KPIC medical insurance plan; or
2. The date the Group Policy is terminated; or
3. The date You or Your representative commits an act of fraud or makes an intentional misrepresentation of a material fact; or
4. The end of the grace period after the Policyholder fails to pay any required Premium to KPIC when due or KPIC does not receive the Premium payment in a timely fashion; or
5. The last day of the month in which You cease to qualify as an Eligible Employee.

The Certificate of Insurance or Evidence of Coverage issued in connection with Your medical plan more fully explain eligibility, effective date and termination provision (if applicable).

The Policyholder pays KPIC monthly Premiums for You and Your enrolled Dependent's coverage. A payroll deduction is made for Your part of the cost.

Dependent's Eligibility Date

A Dependent's eligibility date is the later of: a) Your eligibility date; or b) the date the person qualifies as Your Dependent. A child named in a Qualified Medical Child Support Order qualifies as Your Dependent on the date specified in the court order. An adopted child qualifies as Your Dependent on the earlier of the date of adoption or from and after the moment the child is placed in Your physical custody for adoption.

Effective Date of Dependent's Coverage

A Dependent's Effective Date of insurance is the date determined from the Enrollment Rules that follow.

Dependent's Enrollment Rules

Your Dependents must be enrolled when You first become eligible or on the first day of the month after they become eligible. However, Dependents who are covered under another group dental program are not required to enroll under this coverage. If the other coverage ends, the Dependents may enroll under this coverage within 30 days of the loss of the other coverage. Proof of prior coverage is required.

Court or Administrative Ordered Coverage for a Dependent Child

If a Covered Person is required by a court order to provide health coverage for an eligible child and the Covered Person is eligible for coverage under a family plan, the Covered Person, employee, employer or group administrator may enroll the eligible child under family coverage by sending KPIC a written application and paying KPIC any additional amounts due as a result of the change in coverage. Enrollment period restrictions will not apply in these circumstances. However, the child should be enrolled within 31 days of the court or administrative order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

If the Covered Person, employee, administrator or employer fails to apply for coverage for the Dependent child pursuant to the Order, the custodial parent, district attorney, child's legal custodian or the State Department of Health Services may submit the application for insurance for the eligible child. Enrollment period restrictions will not apply in these circumstances. However, the child must be enrolled within 31 days of the order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

The coverage for any child enrolled under this provision will continue pursuant to the terms of this plan unless KPIC is provided written evidence that:

1. The order is no longer in effect;
2. The child is or will be enrolled in comparable health coverage through another insurer which will take effect on or before the requested termination date of the child's coverage under the Group Policy;
3. Non-payment of Premium.

Effective Date for Future Dependents

If You have Dependent coverage and there would be no extra cost for adding a Dependent to Your coverage. The Effective Date of insurance for a Dependent will be the date You acquire the Dependent. You must notify KPIC that You have a new Dependent within 31 days so that the Dependent can be added to Your coverage. This will also help avoid delays on any claim You might file on the Dependent.

If the cost of Your Dependent coverage would increase when You add a Dependent, You must enroll the Dependent for insurance and agree to pay any additional cost in accordance with the Enrollment Rules. The Effective Date of insurance for that Dependent will be the date determined from the Enrollment

Rules. The Dependent must be enrolled within 31 days of their eligibility date or they will be considered a Late Enrollee.

Exception for Newborns

A newborn Dependent child is automatically covered 31 days from and after the moment of birth. If the cost of Your Dependent coverage would increase because of the addition of a newborn Dependent,

You must enroll the newborn Dependent for insurance and agree to pay the additional cost within 31 days of that Dependent's birth in order for insurance to extend beyond the 31-day period. If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next annual open enrollment period to enroll the child for coverage. If You or Your Dependents are enrolled pursuant to a Late Enrollment Exception because of the birth of a newborn Dependent child, coverage for You and Your spouse is effective from the date of birth of the newborn Dependent child.

If the cost of Your coverage would not increase as a result of the child being enrolled under the coverage, You should still notify Us, in writing, of the child's birth within 31 days. This will allow Us to add the child to Our records and help avoid delays on any claim You might file on the child.

Exception for Adopted Children

An adopted child is insured from the earlier of the date of adoption or from and after the moment the adopted child is placed in the physical custody of the Covered Person for adoption. If the cost of Your Dependent coverage would increase because of the addition of an adopted child, You must enroll the adopted child for insurance and agree to pay the additional cost within 31 days of his eligibility date in order for insurance to extend beyond the 31-day period. If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next annual open enrollment period to enroll the child for coverage. If You or Your Dependents are enrolled pursuant to a Late Enrollment Exception because of the adoption of a Dependent child, coverage for You and Your spouse is effective from the earlier of the date of adoption or from and after the moment the adopted child is placed in the physical custody of the Covered Person for adoption.

If the cost of Your coverage would not increase as a result of the child being enrolled under the coverage, You should still notify Us, in writing, of the child's adoption or placement within 31 days of the event. This will allow Us to add the child to Our records and help avoid delays on any claim You might file on the child.

Dependent's Enrollment Rules

Your Dependents must be enrolled when You first become eligible or on the first day of the month after they become Dependents. However, Dependents who are covered under another group dental program are not required to enroll under this coverage. If the other coverage ends, the Dependents may enroll under this coverage within 30 days of the loss of the other coverage. Proof of prior coverage is required.

Age Limit for Dependent Children

The age limit for Dependent children is up to age 26, unless otherwise stated in the Schedule of Coverage.

Exceptions

The age limits indicated above for Dependent children and the requirement under item b) of the definition of Dependent, do not apply to a Dependent child who is continuously incapable of self-sustaining employment due to a physical handicap or intellectual disability that or biologically based psychiatric disorder diagnosed as such by competent health care professionals that occurred prior to the age limit. Such child will continue to qualify as a Dependent until the earlier of the following dates: a) the date he recovers from the physical handicap or intellectual disability; or b) the date he no longer chiefly depends on You for support and maintenance.

Proof of such incapacity and dependency must be furnished to KPIC within 31 days of the child's

attainment of the limiting age and subsequently as may be required by KPIC, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

We will notify You at least 90 days prior to the date the Dependent child attains the limiting age that the Dependent child's coverage will terminate unless proof of disability is provided to Us within the specified time. Eligibility will continue as long as the Dependent child relies on You for support and maintenance due to a physical handicap or intellectual disability.

IMPORTANT:

KPIC will not deny enrollment of a child under the coverage of a child's parent because the child:

1. Was born out of wedlock;
2. Is not claimed as a Dependent on the parent's federal income tax return; or
3. Does not reside with the parent or in KPIC's service area.

Contributions

You must pay part of the cost of Your Dependent's coverage, unless the Policyholder's Application for coverage specifies that the Policyholder will pay the full cost of a Dependent's coverage.

Termination of an Insured Dependent's Coverage

An enrolled Dependent's insurance will terminate on the earlier of the following dates:

1. The date the Eligible Employee ceases to be covered under a Kaiser HMO or KPIC medical plan insurance plan; or
2. The date the Group Policy is terminated; or
3. The date the Dependent, or Your Dependent's representative, commits an act of fraud or makes an intentional misrepresentation of a material fact; or
4. The end of the grace period after the Policyholder fails to pay any required Premium to KPIC or to its Administrator when due or KPIC or its Administrator does not receive the Premium payment in a timely fashion; or
5. The last day of the month Your Dependent ceases to qualify as a Dependent under the terms of the Group Policy.

TIMELY ACCESS TO CARE

Your coverage provided under this plan may include coverage for Covered Services that are received from either Participating Dentists or Non-Participating Dentists.

The Certificate of Insurance or Evidence of Coverage issued in connection with Your medical plan more fully explain eligibility, effective date and termination provision (if applicable).

The Policyholder pays KPIC monthly Premiums for Your and Your enrolled Dependent's coverage. A payroll deduction is 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

Participating Providers have agreed waiting times to Covered Persons for appointments for dental care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 day days a week;
- for any urgent care, 72 hours for appointments consistent with the Covered Person's individual needs;
- for any non-urgent care, 36 business days; and
- for any preventive services, 40 business days.

During non-business hours, You will have access to Your Provider's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact if You are experiencing an Emergency Dental Condition. If You call Customer Service, a representative will answer Your call within 10 minutes during normal business hours.
If You have any complaints regarding obtaining timely access to dental care, You may call Customer Service at 1-800-835-2244 or You may contact the Consumer Services Division at the California Department of Insurance at 1-800-927-4357 (HELP).

Notice of the Availability of Interpreter Services from a Participating Dentist

We offer qualified interpretation services to limited-English proficient Covered Persons at no cost to them, at all points of contact in any modern language where language assistance is needed, including when a Covered Person is accompanied by a family member or friend who can provide such language interpretation services. Should You need language interpretation services with Your Participating Dentist, You may call Customer Service at 1-800-835-2244 for assistance

PRE-TREATMENT ESTIMATE

NOTE: Pre-Treatment Estimates are neither authorization of coverage nor a binding agreement by KPIC that the benefit is a Covered Service payable under this Certificate.

After a dental examination, Your Provider 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 Provider to request a Pre-Treatment Estimate.

A Pre-Treatment Estimate 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 Group Policy at the time the treatment You have planned is completed. The Pre-Treatment Estimate also includes an estimate of your Out-of-Pocket Cost.

In order to receive a Pre-Treatment Estimate, Your Participating Provider must send a statement of proposed treatment plan along with relevant x-rays to Us listing the proposed treatment. KPIC will send Your Participating Provider a Pre-Treatment Estimate which estimates how much of the treatment costs KPIC will pay and how much You will have to pay. After You review the estimate from Your Participating Provider and You decide to go ahead with the treatment plan, Your Participating Provider returns the statement to KPIC's Administrator at the following address for payment after treatment has been completed.

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

Computations in connection with the Pre-Treatment Estimates are estimates only and are based on what would be payable on the date the Pre-Treatment Estimate is issued if the Covered Person is eligible. Payment will depend on the Covered Person's eligibility and the remaining Benefit Maximum during the Accumulation Period when completed services are submitted to KPIC.

Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date the Group Policy terminates;
- the date Your dental coverage ends; or
- the date the PPO or Premier Dentist's provider agreement with Delta Dental ends.

Pre-Treatment Estimates help prevent any misunderstanding about Your financial responsibilities.

SELECTING YOUR PROVIDER

IMPORTANT

Please read the following information carefully. It will help You understand how the Provider You select can affect the dollar amount You must pay in connection with receiving Covered Services. Your coverage under the Group Policy includes coverage for Covered Services received from Contracted Providers (PPO and Premier Dentists) and from Non-Contracted Providers.

Depending on the Provider You select, You will be responsible for the payment of any amount in excess of the Maximum Contract Allowance but not more than the Accepted Fees of PPO and Premier Dentists and not more than the Submitted Amount for Covered Services rendered by Non-Contracted Providers.

For Covered Services received from:

PPO Dentists: You will have the lowest Out-of-Pocket Costs and biggest savings. PPO Dentists have agreed to accept the PPO Dentist's Accepted Fee as full payment which typically results in lower Coinsurance charged to You.

Premier Dentists: You will be responsible for the payment of any amount in excess of the Maximum Contract Allowance but not more than the Accepted Fee of the Premier Dentist.

Non-Contracted Providers: You will be responsible for the payment of any amount in excess of the Maximum Contract Allowance but not more than the Submitted Amount from the Non-Contracted Provider.

Free Choice of Provider

We recognize that many factors affect the choice of Dentist, and therefore, We support Your right to freedom of choice regarding Your Provider. This assures that You have full access to the dental treatment You need from the dental office of Your choice. You may see any licensed Provider for Your covered treatment. You and Your family members can see different Providers.

With this dental plan, You have full access to see any licensed Dentist for Covered Services:

- Delta Dental PPO Dentist (PPO Dentist)
- Delta Dental Premier Dentist (Premier Dentist)
- Non-Contracted Provider (Non-Contracted Dentist)

Pursuant to 10 CCR 2240.1(e), as then constituted or later amended, if medically appropriate care cannot be provided by a PPO or Premier Dentist, We will arrange for the required care with available accessible Contracted Providers.

We will notify You, within a reasonable amount of time, if You will be materially or adversely affected by the termination, breach of contract or the inability of a Participating Provider to perform.

Remember, You enjoy the greatest Benefits—including Out-of-Pocket Cost savings—when You choose a PPO Dentist. To take full advantage of Your Benefits, We highly recommend You verify Your Dentist's Network status with Your dental office before each appointment. Review the section titled **CLAIM PROVISIONS** for an explanation of payment procedures to understand the method of payments applicable to Your Dentist selection and how that may impact Your Out-of-Pocket Costs.

Locating a PPO or Premier Dentist

There are two ways in which You can locate a PPO Dentist or a Premier Dentist near You:

- Network Visit www.deltadentalins.com to search by location, specialty and Network type; or
- Call Our Customer Service Center toll-free at 1-800-835-2244 and one of Our representatives will assist Network You.

Continuity of Care

Current Covered Persons

If You are a current Covered Person and Your treating PPO or Premier Provider is terminated from the Delta Dental Network before completing a course of treatment, You may have the right to the Benefit of completion of care. Such services include:

- certain acute dental conditions;
- serious chronic dental conditions;
- surgery or other procedure that has been recommended and documented by the terminated PPO or Premier Provider to occur within 180 days of the provider contract's termination date; and
- other specified dental conditions.

Please call Customer Service at 1-800-835-2244 to determine eligibility and/or to request a copy of Our *Continuity of Care Policy*. You must make a specific request to continue under the care of Your terminated PPO or Premier Provider. If You are eligible for this continuity of care Benefit, We will pay for Covered Dental Services up to Your plan's maximum Benefit that applied before the PPO or Premier Provider was terminated and will continue to apply after the termination for each Covered Person in each Calendar Year after the plan Deductible has been satisfied.

If You are a current Covered Person and Your PPO Provider is terminated from the Delta Dental Network before completing a course of treatment, payment will be calculated based on the PPO Maximum Allowance. PPO Providers have agreed to accept the PPO Maximum Allowance as full payment for Covered Dental Services.

If you are a current Covered Person and Your Premier Provider is terminated from the Delta Dental Network before completing a course of treatment, payment will be calculated based on the Premier Maximum Allowance. Since Premier Providers have agreed to accept the Premier Maximum Allowance and not the PPO Maximum Allowance, You may be billed the difference.

We are not required to continue care with Your terminated PPO or Premier Provider if You are not eligible under the terms of this plan or if We cannot reach an agreement with Your terminated PPO or Premier Provider on the terms regarding Your care in accordance with California law.

New Covered Persons

If You are a newly Covered Person and are undergoing a course of treatment with a Non-Contracted Dentist, You may have the right to the Benefit of completion of care with Your Non-Contracted Dentist. Such services include:

- certain acute dental conditions;
- serious chronic dental conditions;
- surgery or other procedure that has been recommended and documented by the Non-Contracted Dentist to occur within 180 days of the newly Covered Person's Effective Date of coverage; and
- other specified dental conditions.

Please call Customer Service at 1-800-835-2244 to determine eligibility and/or to request a copy of Our Continuity of Care Policy. You must make a specific request to continue under the care of Your Non-Contracted Dentist. If You are eligible for this continuity of care Benefit, We will pay for Covered Dental Services based on Your plan up to Your plan maximum Benefit for each Covered Person in each Calendar Year after the plan Deductible has been satisfied.

If You are a newly Covered Person undergoing a course of treatment with a Non-Contracted Dentist, payment will be calculated on the applicable percentage of the lesser of the Non-Contracted Dentist's fee or the PPO Maximum Allowance for Covered Dental Services. Since We cannot limit Non-Contracted Dentist's fees, the amount You pay may be significantly higher.

We are not required to continue care with your Non-Contracted Dentist if You are not eligible under the terms of Your plan or if We cannot reach an agreement with Your Non-Contracted Dentist on the terms regarding Your care in accordance with California law.

Please see the **CLAIM PROVISIONS** section which describes how payments of services are calculated for PPO and Premier Providers and Non-Contracted Dentists.

Emergency Dental Services

Emergency Dental Services are palliative relief, controlling of dental pain, and/or stabilizing the patient's condition. Our Participating Providers are available 24 hours a day, 7 days a week to provide Emergency Dental Services. If You are experiencing an Emergency Dental Condition, You can call 911 (where available).

Urgent Dental Services

An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If You believe that You need Urgent Dental Services, You may visit any PPO or Premier Provider.

Claims for Emergency Dental Service and Urgent Dental Services

If You require Emergency Dental Services or Urgent Dental Services, as described above, and a PPO or Premier Provider is unavailable to provide treatment, You may visit any licensed Dentist of Your choice. This plan will pay for those Benefits had You received treatment from a PPO or a Premier Provider.

Payment for Emergency Dental Services and Urgent Dental Services received from a Non-Contracted Dentist will be based on Your plan's maximum Benefit for each Covered Person in each Calendar Year after Your plan Deductible has been satisfied.

Please see the **CLAIM PROVISION** section which describes how payments of services are calculated when visiting a PPO Dentist, Premier Dentist and a Non-Contracted Dentist.

GENERAL BENEFITS AND LIMITATIONS

Your dental program covers several categories of Benefits when the services are provided by a licensed Provider. We will pay the Percentage Payable of the Maximum Contract Allowance for each Covered Service, subject to certain limitations. You are responsible for paying the Coinsurance and in addition, when seeing a Premier Dentist and Non-Contracted Providers, you will be responsible to pay any amount exceeding the Maximum Contract Allowance up to the Accepted Fee. The Coinsurance is part of Your Out-of-Pocket Cost. You pay this even after a Deductible has been met.

It is to Your advantage to select PPO Dentists because they have agreed to accept the PPO Dentist's Accepted Fee as full payment which typically results in lower Coinsurance charged to You. Please read the **SELECTING YOUR PROVIDER** and **HOW CLAIMS ARE PAID** sections for more information.

Covered Services and Limitations

Unless otherwise indicated in Your Schedule of Coverage, KPIC will pay the percentage payable of the Maximum Contract Allowance for the following Covered Services:

- Diagnostic and Preventive Services:

    1. Diagnostic services are the necessary procedures to assist the Provider in evaluating Your dental health and to determine necessary treatments. Diagnostic services include oral examinations (including initial examinations, periodic examinations and emergency examinations); x-rays; diagnostic casts; examination of biopsied tissue; and specialist consultation.

    2. Preventive services are the necessary procedures and techniques to prevent the occurrence of dental abnormalities or diseases. Preventive services include prophylaxis (cleaning); fluoride treatment; space maintainers.

    Limitations (Diagnostic and Preventive Services):

    1. KPIC will pay for routine 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. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that 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.

    2. X-ray limitations:

        a) KPIC will limit the total reimbursable amount to the Provider's Maximum Contract Allowance for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Maximum Contract Allowance for a complete intraoral series.
        b) When a panoramic film is submitted with supplement film(s), KPIC will limit the total reimbursable amount to the treating Dentist's Maximum Contract Allowance for a complete intraoral series.
        c) If a panoramic film is taken in conjunction with an intraoral complete series. KPIC considers the panoramic film to be included in the complete series.
        d) A complete intraoral series and panoramic film are each limited to once every five (5) years.
        e) Bitewing x-rays are limited to two (2) times per Accumulation Period when provided to Enrollees under 18 and one (1) time per Accumulation Period for Enrollees age 18 and over. Bitewings of any type are not billable to the patient within 12 months of a full mouth series unless warranted by special circumstances.

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

4. Interim caries arresting medicament application is limited to twice per tooth per Calendar Year.

5. 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 tooth within a 5-year period.
   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.

6. Pulp vitality tests are allowed once per date of service when definitive treatment is not performed.

7. Cephalometric x-rays, oral/facial photographic images (once per lifetime) and diagnostic casts (once per lifetime) are covered only when orthodontic services are a Benefit.

8. 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.

- Basic Services:

1. Restorative services provide the necessary procedures to restore the teeth; other than cast restorations. Restorative services include amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).

2. Oral Surgery provides the necessary procedures for the extraction of teeth and certain other surgical procedures, including pre- and post-operative care.

3. Endodontic services provide the necessary procedures for the treatment of tooth pulp.

4. Periodontic services provide the necessary procedures for the treatment of gums and bones that support the teeth.

5. Sealants topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay.

6. Adjunctive General Services include general anesthesia; office visit for observation; office visit after regularly scheduled hours; therapeutic drug injection; treatment of post-surgical complications (unusual circumstances); limited occlusal adjustment: palliative (emergency) treatment of dental pain.

Limitations (Basic Services):

1. Sealant Benefits include the application of sealants only to permanent first molars through age eight and second molars through age 15 if they are without caries (decay), or restoration on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.

2. KPIC will not cover to 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.

3. KPIC limits payment for prefabricated resin crowns under this section to services on baby (deciduous) teeth. Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16.

4. Therapeutic pulpotomy is limited to once per tooth within a 5-year period for baby (deciduous) teeth only.

5. Root canal therapy and pupal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

6. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.

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

8. When allowed, root amputation per root and/or hemisection is limited to once in a 24-hour period. Limited to once per root, per 24-month period.

9. Pin retention is covered not more than once in any 24-month period. Benefit is limited to once per tooth within a 3-month period.

10. Palliative treatment is covered per visit, not per tooth, limited to 3 occurrences within a 6-month period, and the fee includes all treatment provided other than required x-rays or select diagnostic procedures.

11. Periodontal limitations:
    a) Benefits for periodontal scaling and root planning 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, ridge augmentation or implants.
    d) If in the same quadrant, scaling and root planning 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 planning 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.

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

13. The following oral surgery services are limited to age 19 (or ortho limiting age) provided orthodontics are covered; surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, surgical repositioning of teeth.

- Crowns, Inlays, Onlays and Cast Restoration Services:

Note: Please refer to Your Schedule of Coverage to see if Crowns, Inlays, Onlays and Cast Restoration Services are covered under Your plan.

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

Limitations (Crowns, Inlays, Onlays and Cast Restoration Services):

1. Steel crowns and onlays are limited to Enrollees age 15 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. Porcelain crowns and onlays are limited to Enrollees age 16 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.

3. 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.

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

5. 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.

- Prosthodontic Services:

Note: Please refer to Your Schedule of Coverage to see if Prosthodontic Services are covered under Your plan.

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

Limitations (Prosthodontic Services):

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 dental 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 per an Accumulation 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.

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

7. Unless stated otherwise in your Schedule of Coverage, KPIC will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but KPIC 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.

- Orthodontic Services:

Note: Please refer to Your Schedule of Coverage to see if Orthodontic Services are covered under Your plan.

1. Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly. Orthodontic Benefits include Diagnostic casts.

Limitations (Orthodontics Services):

1. If orthodontic treatment has begun before You become eligible for coverage, payments under this plan will begin with the first payment due to the Provider following Your eligibility date.

2. Orthodontics payments under this plan will stop when the first payment is due to the Provider following either a loss of eligibility, or if treatment is ended for any reason before it is completed.

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

4. Benefit for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.

5. Benefits are not paid to repair or replace any orthodontic appliance received under this program.

6. Benefits are not paid for orthodontic retreatment procedures.

Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the orthodontic Maximum Contract Allowance and Maximum Benefit if covered as Benefits under KPIC's standard processing policies.

- 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. A Benefit appropriately provided through teledentistry is covered on the same basis and to the same extent that the Benefit is covered though in-person diagnosis, consultation or treatment.

NOTE: Services that are more expensive than a Generally Accepted Dental Practice Standard procedure is an "Optional Service." If You request an Optional Service, You must pay for the charges in excess of Our share of the Covered Service. Optional Services also include the use of specialized techniques not customarily performed alone under Generally Accepted Dental Practice Standards.

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; An inlay or porcelain/ceramic onlay instead of an amalgam restoration; or
c) 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: If You select a more expensive plan of treatment than is customarily provided, or involved specialized techniques, an allowance will be made for the treatment that meets Generally Accepted Dental Practice Standards. We will pay the applicable percentage of the lesser fee for the customary and standard treatment and You are responsible for the remainder of the Provider's fee. For example: a crown where a silver filling would restore the tooth; or a precision denture where a standard denture would suffice.

To help You improve Your oral health, the following wellness program (sometimes referred to as *Smileaways*) services are available. These benefits are offered in conjunction certain Qualifying Medical Conditions. Please call KPIC at the number on Your ID card 1-800-835-2244, 711 (TTY) or go to deltadentalins.com, to learn more about these benefits.

1. Routine Cleaning & Periodontal Maintenance limited to any combination of four (4) each Calendar Year;
2. Periodontal Scaling & Root Planing once every Calendar Year per quadrant with no more than two (2) quadrants covered on the same date of service.

For purposes of this benefit Qualifying Medical Conditions include one or more of the following conditions:

1. Cardiovascular (Heart Disease);
2. Diabetes;
3. Cerebrovascular Disease (Stroke);
4. HIV/AIDS; and
5. Rheumatoid arthritis

Note: If an Enrollee is eligible for a pregnancy benefit and is also eligible for this wellness program services, the wellness program services shall replace the additional pregnancy benefits. Upon showing proof of pregnancy, however, the Enrollees will be entitled to one additional oral exam each Calendar Year.

Value-added Benefits:

The following *wellness program* services are available to You. These value-added benefits are offered in conjunction with this plan and are not Covered Services under the Group Policy. Please call KPIC at the number on Your ID card 1-800-835-2244, 711 (TTY), to learn more about the following value-added benefits and for a complete and updated list of wellness program services offered to You.

1. Coverage for one periodontal scaling and root planing procedure per quadrant
2. prophylaxis (teeth cleaning)
3. periodontal maintenance procedure

For purposes of this section, "*wellness program"* means value-added services offered to Covered Persons that do not constitute Covered Services under the Group Policy. These services may be discontinued at any time without prior notice.

NOTE: Note on additional Benefits during pregnancy:

When an Enrollee is pregnant, KPIC 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 Group Policy 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.

IMPORTANT: If You opt to receive dental services that are non-covered services under the Group Policy, Your Dentist may charge You their usual and customary rate for those services. Prior to providing You with dental services that are non-covered services, Your Dentist should provide You with 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 Your dental coverage options, You may call KPIC at 1-800-835-2244. To fully understand Your coverage, You may wish to carefully review this Certificate.

GENERAL EXCLUSIONS AND LIMITATIONS

This plan covers a wide variety of dental care expenses but there are some that are not covered. It is important for You to know what services are not covered before visiting Your Dentist. Unless specifically stated otherwise in the Group Policy, in Your Schedule of Coverage or elsewhere in this Certificate, no payment will be made for any treatment or service in connection with the following:

1. Any treatment or procedure not listed as Covered Services under the **General Benefits and Limitations** section.
2. Charges in excess of plan Benefit Maximums.
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 Enrollee by any Federal or State Governmental Agency or are provided without cost to the Enrollee 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 maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. 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 that have not been accepted under Generally Accepted Dental Practice Standards.
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 given by a licensed Provider in connection with covered oral surgery procedures.
12. Extraoral grafts (grafting of tissues from outside the mouth to oral tissue).
13. Unless stated otherwise in your Schedule of Coverage, 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 tooth decay. Tooth decay is also called dental cavities or dental caries and involves the destruction of the surface of a tooth.
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. Crowns, Inlays, Onlays and Cast Restoration*.
21. Prosthodontic Services*.
22. Charges for speech therapy.
23. Charges for lost or stolen appliances.
24. Services for which no charge is normally made in the absence of insurance.
25. 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 broken appointments.

26. Orthodontic treatment except for eligible Dependent children under Plan E with orthodontics.
27. Treatment plans that are higher level of services than Generally Accepted Dental Practice Standards or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice.
28. Maxillofacial prosthetics.
29. Provisional and/or temporary restorations except an interim removable partial denture is covered only to replace extracted anterior permanent teeth during the healing period.
30. Cosmetic procedures and treatments performed to solely enhance appearance and which is not a treatment provided for the patient's dental health under Generally Accepted Dental Practice Standards. Examples include, but are not limited to: treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury.
31. Laboratory processed crowns for Enrollees under age 12.
32. Fixed bridges and removable partials for Enrollees under age 16.
33. Interim implants.
34. Indirectly fabricated resin-based inlays and onlays.
35. Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
36. Services or supplies covered by any other health plan of the Policyholder.
37. Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
38. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Group Policy, will be the responsibility of the Enrollee and not a covered Benefit.
39. Deductibles amounts over plan maximums and/or any service not covered under the dental plan.
40. 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.
41. Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.

* These exclusions do not apply to PPO Plan E, PPO Plan E w/Ortho, and PPO Plan G. Please check the Schedule of Coverage for more information.

Time Effective

The effective time for any dates used is 12:01 AM at the address of the Policyholder.

Incontestability

Any statement made by the Policyholder or a Covered Person in applying for insurance under the Group Policy will be considered a representation and not a warranty. No statement made by any person shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary. After the Group Policy has been in force for 2 years, its validity cannot be contested except for non-payment of Premiums or fraudulent misstatement as determined by a court of competent jurisdiction. After a Covered Person's insurance has been in force for 2 years during his or her lifetime, its validity cannot be contested due to misstatement other than a fraudulent misstatement. Only statements that are in writing and signed by the Covered Person can be used in a contest.

Notice of Claims

You must give Us written notice of claim after the occurrence or commencement of any loss covered by the Policy, or as soon as reasonably possible. You may give notice or may have someone do it for You. The notice should give Your name and Your policy number. Notice given by or on behalf of You to Us at the address listed below, or to any KPIC authorized agent, with information sufficient to identify the Covered Person, shall be deemed notice to KPIC.

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

Proof of Loss

Written Proof of Loss must be sent to Us or to Our Administrator at the address shown above within 90 days after the date of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, but in no event, later than one year from the time proof is otherwise required, except in the absence of legal capacity.

Time for Payment of Claims

Subject to due written Proof of Loss, all indemnities for loss for which this policy provides payment will be paid to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Insured Employee immediately, but no later than 30 days upon receipt of due written proof.

Contested Claims

If KPIC is unable to pay Your claim after receiving proper Proof of Loss, KPIC will notify You of any contest to or denial of the claim within 30 working days of the date the Proof of Loss was received by KPIC. The written notice will specify:

1. the parts of the claim that are being contested or denied;
2. the reasons the claim is being contested or denied; and
3. the pertinent provisions of the Group Policy on which the contest or denial is based.

If the Covered Person is dissatisfied with the result of the review, the Covered Person may file an appeal.

Legal Actions

No action at law or in equity may be brought to recover under the Group Policy prior to the expiration of 60 days after the claim has been filed as required by the Group Policy. Also, no action may be brought after 2 years from the expiration of the time within which proof of loss is required by the Group Policy.

Overpayment

KPIC will not withhold any portion of a claim payment on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior Claim unless:

1. KPIC's files contain clear, documented evidence of an overpayment and written authorization from the claimant or assignee, if applicable, permitting such withholding procedure; or
2. KPIC's files contain clear, documented evidence of all of the following:
    a) the overpayment was erroneous under the provisions of the Policy;
    b) the error which resulted in the payment is not a mistake of law;
    c) KPIC notifies the claimant within 6 months of the date of the error, except that in instances of errors prompted by representations or nondisclosure of claimants or third parties, KPIC notifies the claimant within 15 calendar days after the date of discovery of such error. For the purpose of this provision, the date of the error is the day on which the draft for benefits is issued; and
    d) such notice states clearly the cause of the error and the amount of the overpayment; however, the procedure set forth above will not be used if the overpayment is the subject of a reasonable dispute as to facts.

With each payment, KPIC will provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the provider's name or service covered, dates of service, and a clear explanation of the computation of benefits. In case of an Adverse Benefit Determination, it will also include a notice that will tell You why We denied Your claim and will include information regarding the mandatory appeals rights, including external review, that may be available to You.

For claims related to Your dental benefits:

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

Misstatement of Age

If the age of any person insured under the Group Policy 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).

Examination

When reasonably necessary, KPIC, at its own expense, may require an examination of the person for whom a claim is made.

Money Payable

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

COORDINATION OF BENEFITS

Application

This Coordination of Benefits provision applies when the Covered Person has coverage under more than one Plan. If this provision applies, the benefit determination rules state whether this Plan pays before or after another Plan.

The Benefits of this Plan:

1. Will not be reduced when this Plan is primary;
2. May be reduced when another Plan is primary and this Plan is secondary. The Benefits of this Plan are reduced so that they and the benefits payable under all other Plans do not total more than 100% of the Allowable Expenses during any Accumulation Period.
3. Will not exceed the Benefits payable in the absence of other coverage.

Order of Benefit Determination Rules

This Plan determines its order of benefits by using the first of the following that applies:

1. General: A Plan that does not coordinate with other Plans is always the primary Plan.

2. Nondependent\Dependent: The benefits of the Plan which covers the person as an employee is the primary Plan; the Plan which covers the person as a Dependent is the secondary Plan.

3. Dependent Child--Parents Not Separated or Divorced: When this Plan and another Plan cover the same child as a Dependent of different parents, benefits for the child are determined as follows:
   a. The primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The secondary Plan is the Plan of the parent whose birthday falls later in the year.
   b. If both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the primary Plan; the Plan which covered the parent the shorter time is the secondary Plan.
   c. If the other Plan does not have the birthday rule, but has the male\female rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. Dependent Child--Separated Or Divorced Parents: If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined as follows:
   a. First, the Plan of the parent with custody of the child;
   b. Then, the Plan of the spouse of the parent with custody of the child; and
   c. Finally, the Plan of the parent without custody of the child.

   However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the primary Plan. This paragraph does not apply with respect to any Accumulation Period during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the provider, if the custodial parent so requests.

5. Active\Inactive Service: The primary Plan is the Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's Dependent). The secondary Plan is the Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

6. Longer\Shorter Length Of Coverage: If none of the above rules determines the order of benefits the primary Plan is the Plan which covered an employee the longer time. The secondary Plan is the Plan which covered that person the shorter time.

COORDINATION OF BENEFITS

Effect of Medicare

This Plan will be primary to Medicare for an Eligible Employee and Dependent spouse of such - Eligible Employee. This Plan will not be primary to Medicare if the Eligible Employee is eligible for Medicare as primary. Any such Eligible Employee may not continue enrollment under this Plan. Medicare is primary for an insured Retiree or the Dependent spouse of a Retiree age 65 or over; who are not working aged under the Working Aged Provisions (TEFRA/DEFRA) of the federal law and those 65 or over who are eligible for Medicare due to “ESRD” (End Stage Renal Disease. This applies whether or not the Retiree or spouse is enrolled in Medicare. This prohibition includes Senior Advantage.

Non-Duplication of Benefits

In instances where Medicare is your primary dental coverage, benefits provided under this Group Policy will be provided in accordance with the provisions of this Group Policy, less any amount paid by Medicare as primary dental coverage. Benefits payable by KPIC, if any, as the secondary dental coverage makes up the difference between the amount Medicare pays and the benefits that otherwise would be payable under this Group Policy. Total amount paid by Medicare as primary and KPIC as secondary will not exceed the amount payable by KPIC if there were no other coverage.

Effect of No-fault Auto Coverage

No-fault auto coverage is considered the primary Plan.

Reduction in this Plan's Benefits

When the Benefits of this Plan are reduced, each Benefit is reduced in proportion. It is then charged against any applicable Maximum Benefit of this Plan.

Any Benefit amount not paid under the Group Policy because of coordinating benefits becomes a Benefit credit under the Group Policy. This amount can be used to pay any added Allowable Expenses the Covered Person may incur on the same claim.

Right to Receive and Release Information

Certain facts are needed to coordinate Benefits. KPIC or its Administrator has the right to decide which facts it needs. KPIC or its Administrator may get needed facts from or give them to any other organization or person. KPIC or its Administrator need not tell, or get the consent of any person to do this. Each person claiming Benefits under this plan must give KPIC or its Administrator any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may have included an amount which should have been paid under this Plan. If it does, KPIC or its Administrator may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under this Plan. KPIC or its Administrator will not pay that amount again. The term **"payment made"** includes providing Benefits in the form of services. In this case **"payment made"** means the reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by KPIC or its Administrator is more than it should have paid, KPIC or its Administrator may recover the excess from one or more of the following:

1. the persons KPIC or its Administrator has paid or for whom it has paid.
2. insurance companies.
3. other organizations.

COORDINATION OF BENEFITS

The **"amount of payments made"** includes the reasonable cash value of any benefits provided in the form of services.

Definitions Related to Coordination of Benefits

Active Service means that an employee: (1) is present at work with the intent and ability to work the scheduled hours; and (2) is performing in the customary manner all of the regular duties of his or her employment.

Allowable Expenses means the percentage payable of the Maximum Contract Allowance for medical or dental care or treatment. Part of the expenses must be covered under at least one of the Plans covering the Covered Person.

Coordination Of Benefits means the way benefits are payable under more than one medical or dental plan. Under Coordination of Benefits, the Covered Person will not receive more than the Allowable Expenses for a loss.

Plan means any of the following that provides medical or dental benefits or services:

1. The Group Policy.
2. Any group, blanket, or franchise health insurance.
3. A group contractual prepayment or indemnity Plan.
4. A health maintenance organization (HMO), whether a group practice or individual practice association.
5. A labor-management trustee Plan or a union welfare Plan.
6. An employer or multi-employer Plan or employee benefit Plan.
7. A government program.
8. Insurance required or provided by statute.

Plan does not include any:

1. Individual or family policies or contracts, except no-fault auto coverage.
2. Public medical assistance programs.
3. Group or group-type hospital indemnity benefits of $100 per day or less.
4. School accident-type coverages.

The benefits provided by a Plan include those that would have been provided if a claim had been duly made.

Primary Plan\Secondary Plan means that when this Plan is primary, its benefits are determined before those of the other Plan; the benefits of the other Plan are not considered. When this Plan is secondary, its benefits are determined after those of the other Plan; its benefits may be reduced because of the other Plan's benefits. When there are more than two Plans, this Plan may be primary as to one and may be secondary as to another.

IMPORTANT: If one plan complies, and the other Plan does not, the following rules apply:

1. If the complying Plan is Primary, the complying Plan pays first.
2. If the complying Plan is Secondary, the complying Plan pays immediately, but pays Secondary benefits.

NOTE: If the non-complying Plan refuses to provide information on the level of benefits payable, the complying Plan will assume that the non-complying Plan provides identical benefits and will pay accordingly.

If the non-complying Plan is Primary, and its benefits are reduced to an amount which is less than what the Secondary complying plan would have paid if it were Prime, then, the complying Plan

must provide the difference in benefits up to the amount the complying Plan would have paid as the Prime plan, less any amount previously paid.

By making this advance in benefits, the complying Plan receives all rights of the Covered Person against non-complying Plan.

CLAIM PROVISIONS

All claims under the Group Policy will be administered by:

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

KPIC will pay PPO Dentists and Premier Dentist directly for Covered Services performed by such Contracted Providers.

KPIC will pay the Covered Person directly for Covered Services provided by a Non-Contracted Provider. 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 Group Policy on which the denial is based, and (3) information concerning the Covered Persons right of appeal.

If the denial of Benefits is due to a PPO or Premier Dentist failing to make a timely submission of claim, You shall not be liable to that PPO or Premier 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 — PPO Dentist

Payment for Covered Services performed for You by a PPO Dentist is calculated based on the lesser of the Accepted Fee of the PPO Dentist; or the Submitted Amount.

KPIC calculates the Percentage Payable using the applicable percentage shown in the Schedule of Coverage and sends the payment directly to the PPO Dentist who has submitted the claim. We advise You of any changes not payable by Us for which You are responsible. These charges are generally:

- Your share of the Maximum Contract Allowance; or
- Coinsurance or the Deductible; or
- charges where the Maximum Benefit has been exceeded, and/or
- charges for non-covered services.

Under this plan, seeing a PPO Dentist may reduce Your Out-of-Pocket Cost as Accepted Fees with PPO Dentists are lower. Additionally, when Covered Services are provided by PPO Dentists, subject to the provisions of this Certificate, You will not be responsible for any additional Out-of-Pocket Costs other than Your Coinsurance and Deductible, if such have not yet been satisfied.

Payment for Services — Premier Dentist

Payment for Covered Services performed for You by a Premier Dentist is calculated based on the lesser of the Accepted Fee of the PPO Dentist for a PPO General Dentist in the same geographic area or the Submitted Amount.

KPIC calculates the Percentage Payable using the applicable percentage shown in the Schedule of Coverage and sends the payment directly to the Premier Dentist who has submitted the claim. We advise You of any changes not payable by Us for which You are responsible. These charges are generally:

- Your share of the Maximum Contract Allowance or Coinsurance,
- the Deductible,
- charges where the Maximum Benefit has been exceeded, and/or
- charges for non-covered services.

Under this plan, if You receive Covered Services from a Premier Dentist, You will be responsible for the payment of any amount in excess of the Maximum Contract Allowance but not more than the Accepted Fee of the Premier Dentist.

Payment for Services — Non-Contracted Provider

Payment for services performed for You by a Non-Contracted Provider is also calculated based on the lesser of the Accepted Fee of the PPO Dentist for a PPO General Dentist in the same geographic area; or the Submitted Amount.

When dental services are received from a Non-Contracted Provider, You are responsible for payment of the Non-Contracted Provider's Submitted Fee. You may be required to pay the Non-Contracted Provider Yourself and then submit a claim to Us for reimbursement. Since Our payment for services You receive may be less than the Non-Contracted Provider's Submitted Fee, 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 PPO or Premier Dentist, We recommend that You first discuss the matter with that 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. PPO Dentists and Premier Dentists will fill out and submit Your claims paperwork for You. Some Non-Contracted Providers may also provide this service upon Your request. If You receive services from a Non-Contracted Provider 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 the PPO and Premier Dentists, payment is sent directly to the treating PPO or Premier Dentist. If the Covered 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 a Covered Person'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 Covered Person in each Accumulation Period.

Time Limitations

If any time limitation provided in the Group 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 Group 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.

CLAIMS DISPUTE IMPORTANT NOTICE

If You believe that a claim has been wrongfully denied or rejected, You may have the matter reviewed by the California Department of Insurance. However, You should first contact KPIC to try and resolve the dispute. If the dispute is not resolved, You may contact the California Department of Insurance.

You may call KPIC to make a complaint concerning a claim at the following number: 1-800-835-2244
You may also write to KPIC at:

Kaiser Permanente Insurance Company
P.O. Box 24223
Oakland, CA 94623-1223

Or write to Our Administrator at:

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

You may contact the California Department of Insurance to obtain information on companies, coverage, rights or complaints at:

1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

You can also access on to the California Department of Insurance's website address at:

http://www.insurance.ca.gov/

You may write the California Department of Insurance at:

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

ERISA CLAIMS AND APPEALS PROCEDURES

If Your employee benefit plan is covered by Title I of the Employee Retirement Income Security Act of 1974 (ERISA), the following claims and appeals procedures will apply to benefit claims arising under the Group Policy. The provisions below preempt any conflicting provisions in this Certificate to the extent that the conflicting provisions prohibit implementation of requirements under ERISA. To determine whether Your employee benefit plan is covered by ERISA, check with Your employer.

Definitions

For the purpose of this section of this Certificate, the following definitions apply:

Adverse Benefit Determination (Denial) means either a failure or decision not to provide or make payment, in whole or in part, for a Claim for Benefits. It can be in the form of either a Pre-Service Claim Denial, Concurrent Care Claim Denial or Post Service Claim Denial that results in:

1. a reduction in benefits (other than by cancellation of the Group Policy);
2. a failure or refusal to cover an item or service;
3. a determination that an expense is experimental or investigational;
4. a determination that an expense is not Medically Necessary or appropriate.

Benefit Determination means a decision, either positive or negative, concerning the claimant's right to receive benefits under a group health plan.

Claims Procedures means 1) procedures governing the filing and adjudication of benefit claims, whether Pre-Service Claims, Concurrent Care Claims, or Post-Service Claims; 2) notification of Benefit Determinations; and 3) appeals of a Denial.

Claim for Benefits means a request for plan benefits made by a claimant in accordance with Our Claims Procedures. Claims for Benefits include Pre-Service Claims (if applicable), Concurrent Care Claims and Post-Service Claims.

Concurrent Care Claim means a request for approval of a benefit or treatment where the terms of the Group Policy condition continued receipt of the benefit, in whole or in part, on approval of the benefit in advance of continuing medical care. Concurrent care review requirements, explained elsewhere in this Certificate, apply to Concurrent Care Claims. Concurrent Care Claims can be either Urgent Care Claims or Non-urgent Care Claims.

Non-Urgent Care Claim means anything that is not an Urgent Care Claim.

Post-Service Claim means a Claim for Benefits involving the payment or reimbursement of costs for medical care that has already been received.

Pre-Service Claim means a request for approval of a Benefit or treatment where the terms of the Group Policy condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care. A Pre-Treatment Estimate, explained elsewhere in this Certificate, does not apply to Pre-Service Claims. Pre-Service Claims can be either Urgent Care Claims or Non-Urgent Care Claims.

Urgent Care Claim means a request for approval of Benefits or treatment where delay could seriously jeopardize Your life, health or ability to regain maximum function, or would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the services You are requesting.

The Claims Process (Initial Review)

A Benefit Determination will be made in accordance with the following rules:

1. Urgent Care Claims - We will notify You within 24 hours if We need additional information to make a benefit determination on such claims, or if You or Your representative failed to follow proper procedures that would result in a claim Denial. If additional information is requested,

You will be allowed 48 hours in which to provide such information. We will make a final determination for this type of claim within 48 hours following the earlier of: a) receipt of the requested information from You; or b) the end of the period allowed for providing the information. Decisions regarding Urgent Care Claims will be communicated to You by telephone within 24 hours. They will be confirmed in writing within 3 calendar days of the initial decision.

2. Concurrent Care Claims (Ongoing Course of Treatment) – When a course of treatment will be limited or ended early as a result of a concurrent claim review, We will notify You of Our decision sufficiently in advance to allow You to file a timely appeal of Our decision.

3. Concurrent Care Claims (Additional Treatment) – We will make decisions involving a request for additional treatment, when a previously approved course of treatment is about to end, within 24 hours following receipt of such a request, provided that You make this type of request at least 24 hours prior to the time that treatment is scheduled to end. If the request for concurrent care review is urgent, such request will be handled like any other Urgent Care Claim.

4. Non-Urgent Pre-Service Care Claims (if applicable) – We will make decisions within a maximum of 15 calendar days after receipt of the Pre-certification request. This time period may be extended one time by Us, for up to 15 calendar days, if We determine that an extension is necessary due to matters beyond Our control and notify You of the extension within the initial 15-day period. Any such notice will detail the circumstances requiring the extension and the date upon which We expect to render a decision on Your Claim for Benefits. If such an extension is necessary due to Your failure to submit any necessary information, the notice of extension will describe the required information.

5. Post-Service Claims – We will adjudicate such claims within an initial period of 30 calendar days. This time period may be extended one time by Us, for up to 15 calendar days, if We determine that an extension is necessary due to matters beyond Our control and notify You of the extension within the initial 30-day period. Any such notice will detail the circumstances requiring the extension and the date upon which We expect to render a decision on Your Claim for Benefits. If such an extension is necessary due to Your failure to submit any necessary information, the notice of extension will describe the required information.

You must respond to requests for additional information within 45 calendar days or We will make Our decision on Your Claim for Benefits based upon the information We have available to Us at that time. In the case of an Urgent Care Claim, You must respond to Our request for information within 48 hours.

We will notify You when We approve or deny a Claim for Benefits. If We deny Your Claim for Benefits the notification will include the following information:

1. The specific reason or reasons for the Denial;
2. Reference to the specific provisions in the Group Policy on which the Denial is based;
3. A description of any additional material or information needed for Us to reevaluate Your Claim for Benefits.
4. An explanation of why such material or information is necessary in order for Us to reevaluate Your Claim;
5. A description of the review (appeal) procedures and the time limits applicable to such procedures;
6. A statement of Your rights under section 502(a) of ERISA following a Denial on Your appeal;
7. If any internal rule, guideline, protocol or other similar criterion was relied upon in making the Denial, an offer to provide the rule;
8. If the Denial was based upon Medical Necessity, experimental treatment or similar exclusions or limitations, an offer to provide the specific basis for the Denial.

The Appeals Process

In order to afford You the opportunity for a full and fair review of a Denial, the Policyholder has designated KPIC as the "named fiduciary" for appeals arising under the Group Policy. You may appeal an Adverse Benefit Determination (Denial) to Us. Such appeals will be subject to the following:

1. You may appeal a Denial any time, up to 180 days following the date You receive a notification of Denial;

2. Our review of Your appeal will not afford deference to the initial Denial. This review will be conducted by a committee comprised of individuals who are neither the person who made the initial Denial that is the subject of the appeal, nor the subordinate of such person;

3. In deciding an appeal of any Denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, We will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In the case of a claim involving Urgent Care, We will provide for an expedited review process. You may request an expedited appeal of a Denial orally or in writing. All necessary information, including Our approval or Denial of the appeal, will be transmitted by telephone, facsimile, or other available and similarly expeditious method.

We will generally notify You of Our decision on Your appeal within the following time frames:
1. For Urgent Care Claims, We will provide You with Our decision within 72 hours after We receive Your request for an appeal of a Denial.
2. For Pre-service Claims (if applicable), We will provide You with Our decision within 30 days after We receive Your request for an appeal of a Denial.
3. For Post-service Claims, We will provide You with Our decision within 60 days after We receive an appeal of a Denial.

We will notify You when We approve or deny Your appeal of Our Denial. If We deny Your appeal, the notification will include the following information:

1. The specific reason or reasons for the Denial;
2. Reference to the specific provisions in the Group Policy on which the Denial was based;
3. Your right to obtain reasonable access to, and copies of, all documents, records and other information relevant to Your Claim for Benefits; An explanation of any procedures for You to follow to request a voluntary level of appeal, if applicable;
4. A statement of Your rights under section 502(a) of ERISA following a Denial on Your appeal;
5. If any internal rule, guideline, protocol or other similar criterion was relied upon in making the Denial, an offer to provide the rule, guideline, protocol or similar criterion;
6. If the Denial was based upon Medical Necessity, experimental treatment or similar exclusions or limitations, an offer to provide the specific basis for the Denial.

If You are not satisfied with Our decision after You have exhausted the appeals process, Your remaining remedies may include:

1. A voluntary review of Your Claim for Benefits by Us;
2. The right to bring suit in Federal Court under Section 502(a) of ERISA;
3. Additional rights under state law, including the right to pursue independent external review;
4. Voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency.

NOTE: Any questions about Your rights under ERISA should be directed to the plan administrator named in Your employer's ERISA plan document or the nearest area office of the U.S. Department of Labor, Labor-Management Services Administration.

CONTINUATION OF COVERAGE

You or Your Dependents may be entitled to continue coverage under this plan, at Your expense, under applicable federal (COBRA) or state law (Cal-COBRA), when coverage terminates under the provisions of the Policy. Continued coverage will be: (A) available only to those Covered Persons who qualify at the time a qualifying event occurs; and (B) subject to the terms and conditions of the Policy.

A child that is born to or placed with an Insured Employee during a period of COBRA or Cal- COBRA coverage is eligible for coverage as a Dependent provided proper written notice and election takes place.

Continuation of Coverage under Federal Law (COBRA)

This section only applies to Participating Employers who are subject to Public Law 99-271 (COBRA)

You or a covered Dependent may have a right to have health coverage continued under the Policy when coverage terminates under the provisions of the Policy. Continued coverage will be: (A) available only to those Covered Persons who qualify at the time a qualifying event occurs; and (B) subject to the terms and conditions of the Policy.

A child that is born to or placed with an Insured Employee during a period of COBRA coverage is eligible for coverage as a Dependent provided proper written notice and election takes place.

Qualifying Events

(A) If Your health insurance coverage ends due to (1) termination of employment; or (2) a reduction in hours, You may continue health coverage under the policy for the continuation of coverage period. The right to continue coverage under this provision will not be allowed if KPIC is informed by the employer that Your employment was terminated due to gross misconduct.

(B) If Your Dependent's insurance coverage ends due to: (1) Your death; (2) Your legal divorce or legal separation from Your spouse; or (3) Your child reaching the limiting age for a Dependent, the terminated Dependent has the option to continue health coverage under the policy for the continuation of coverage period.

(C) If You retired from employment with the employer and Your health insurance coverage, or the health insurance coverage of Your Dependents, including Your surviving spouse:
   (1) is substantially eliminated as a result of the employer's filing of a Title XI bankruptcy; or
   (2) was substantially eliminated during the Accumulation Period preceding the employer's filing of a Title XI bankruptcy,

   You and Your Dependents may continue health coverage under the policy for the continuation of coverage period.

(D) If You become entitled to Medicare benefits under Title XVIII of the Social Security Act, Your Medicare ineligible spouse and Dependent eligible children may continue health coverage under the policy for the continuation of coverage period.

Continuation of Coverage Period

"Continuation of Coverage Period", as used in this provision, means the period of time ending on the earlier of:

1. 18 months following qualifying event (A) except if a qualifying event (B) occurs during these 18 months, the continuation of coverage period will be extended an additional 18 months for a total period of 36 months.
2. 36 months following qualifying event (B);
3. for a qualifying event (C):
   a) the date of Your death, at which time Your dependents (other than Your surviving spouse in (i) below) will be entitled to continue coverage on the same basis as if a qualifying event (B) had occurred.
   b) if You died before the occurrence of a qualifying event (C), Your surviving spouse is entitled to lifetime coverage.

4. the end of a 36-month period following an event described in qualifying event (D), without regard to whether that occurrence is a qualifying event, or for any subsequent qualifying event;
5. the date You or Your dependents become covered under any other group coverage providing hospital, surgical medical or dental benefits, insured or self-insured, which does not contain any limitation with respect to any preexisting condition;
6. the date a Covered Person, other than those provided continuation of coverage under qualifying event (C) becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
7. the date the employer ceases to provide any group health coverage for its employees;
8. the date any premium for continuation of coverage is not timely paid; or
9. the date that the privilege for conversion to an individual or family policy is exercised.

Requirements

You or Your Dependent must notify the employer within 60 days of the following qualifying events:
1. the date You and Your spouse were legally divorced or legally separated; or
2. the date the coverage for Your Dependent child ceases due to reaching the limiting age.

The option of electing continuation of coverage lasts for a 60 day period which begins to run at the later of either the date of the qualifying event or the date the Covered Person who would lose coverage due to the qualifying event receives notice of his or her rights to continuation of coverage.

If You or Your Dependent elects to continue coverage for the continuation of coverage period, it will be Your duty to pay each monthly premium, after the initial payment, to the employer one month in advance. The premium amount will include that part of premium formerly paid by Your employer prior to termination. Premiums for each subsequent month will be paid by You or Your Dependent without further notice from the employer.

In any event, KPIC will not be required to provide a continuation of coverage under this provision unless KPIC has received:
1. a written request for continuation, signed by You or Your Dependent; and
2. the premium for the period from the termination date to the end of the last month for which Your employer has paid the group premium.

If Your Employer Group's size changes to 19 or fewer employees and Your employer is required to comply with Cal-COBRA, this will not affect You and Your coverage if You were already enrolled in Federal COBRA.

If You (i) have elected COBRA coverage through another health plan available through Your Employer Group, and (ii) elect to receive COBRA coverage through KPIC during an open enrollment, You will be entitled to COBRA coverage only for the remainder, if any, of the maximum coverage period permitted by COBRA, subject to the termination provisions described above.

Extension for Disabled Covered Persons

If Social Security, under its rules, determines that a Covered Person was disabled when a qualifying event set forth in "B" occurred, the 18 month maximum period of continued health coverage for such a qualifying event may be extended 11 months for a total period of 29 months. To obtain that extension, the Covered Person must notify the employer of Social Security's determination before the initial 18-month maximum period ends.

For the continued health coverage of disabled Covered Persons that exceeds 18 months, KPIC may increase the premium it charges by as much as 50%. The employer may require the disabled Covered Persons to pay all or part of that total increased premium.

In no event will continued health coverage extend beyond the first month to begin more than 30 days after Social Security determines that the Covered Person is no longer disabled. The Covered Person must notify the employer within 30 days of the date of such a Social Security determination.

Extension of Coverage After Exhaustion of COBRA

If a Covered Person has exhausted continuation of coverage under COBRA and or Cal-COBRA (if applicable) and the Covered Person was entitled to less than 36 months of COBRA and or Cal-COBRA (if applicable) coverage, such continuation of coverage may be extended to a maximum of 36 months from the effective date of the COBRA coverage.

Continuation of Coverage under California COBRA (Cal COBRA)

This sub-section only applies to small employer groups with 2-19 eligible employees who are subject to California COBRA (Cal-COBRA) and who are not offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as then constituted or later amended (COBRA).

Eligibility

A Covered Person may have a right to continue coverage when coverage terminates under the provisions of the Policy. Continued coverage will be: (A) available only to those Covered Persons who qualify at the time a qualifying event occurs; and (B) subject to the terms and conditions of the Policy.

A child that is born to or placed with a Covered Person during a period of Cal-COBRA coverage is eligible for coverage as a Dependent provided proper written notice and election takes place.

Individuals Not Eligible for Cal-COBRA Continuation

Continuation of coverage under this provision is not available to and will not be provided for the following individuals:

1. Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as then constituted or later amended.
2. Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan. that provides coverage to individuals and that does not impose any exclusion or limitation with respect to any preexisting condition, other than a preexisting condition limitation or exclusion that does not apply to or has been satisfied due to prior creditable coverage;
3. Individuals who are covered, become covered, or are eligible for federal COBRA coverage, except those individuals, who under applicable California law, are eligible for an extension of COBRA coverage.
4. Individuals who are covered, become covered, or are eligible for coverage pursuant to chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1;
5. Individuals who do not meet the notice requirements of this State Continuation of Coverage provision or fail to make the election in a timely manner;
6. Individuals who do not submit the correct premium amount for the continuation coverage as required by the Group Policy or who fail to satisfy other terms and conditions of the Group Policy.

Qualifying Events

Individuals will qualify for Cal-COBRA as follows:

A) If Your health insurance coverage ends due to: (1) termination of employment; or (2) reduction in Your employment hours, You may continue health coverage under the Group Policy for the continuation of coverage period. The right to continue coverage under this provision will not be allowed if Your employment was terminated due to gross misconduct.

B) If Your Dependent's insurance coverage ends due to: (1) Your death; (2) Your divorce or legal separation from Your spouse or Domestic Partner; or (3) Your Dependent reaching the limiting age for a Dependent.

C) If You become entitled to Medicare benefits under Title XVIII of the Social Security Act, as then constituted or later amended, Your Medicare ineligible spouse and Dependent eligible children may continue health coverage under the policy for the continuation of coverage period.

Termination of Cal-COBRA Continuation Coverage

Cal-COBRA coverage continues only upon timely payment of applicable monthly premiums to KPIC. Coverage will terminate on the earliest of:

1. the date the Covered Person requests coverage be terminated;
2. 18 months after the date the Covered Person's benefits under the Policy would have terminated because of the qualifying events set forth under (A) above;
3. the end of the grace period for which premium payments were made if the Covered Person ceases or fails to make timely premium;
4. 36 months after the date the Covered Person's benefits under the Policy would have terminated because of the qualifying events set forth under (B) and (C) above.
5. the date the individual is no longer eligible for continuation coverage as set forth under the **Individuals Not Eligible for Cal-COBRA Continuation** provision above;
6. the date the employer or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees;
7. the date the Covered Person moves out of KPIC's service area;
8. the date the Covered Person, or their representative, commits fraud or deception in using or obtaining the benefits provided under the Group Policy.

If a Covered Person's continuation coverage under the Group Policy is going to terminate earlier than specified by the Group Policy, the employer must notify the person of their right to obtain continuation coverage under the employer's new group coverage for the remainder of the continuation period. The employer must provide this notice to persons insured under the continuation of coverage provision on the later of:

1. 30 days prior to the termination of the Group Policy; or
2. at the same time all Insured Employees are notified of the termination of the Group Policy.

The employer must also notify the succeeding carrier, in writing, of all individuals who are receiving continuation coverage so that necessary continuation election information can be forwarded to those individuals.

Extension For Disabled Covered Persons

A Covered Person may be eligible for an extension of Cal-COBRA continuation if all the following apply:

1. the Covered Person is:
   a. a former employee who has Cal-COBRA continuation because of the occurrence of event (A) listed under the Qualifying Events section of this provision; or
   b. a Dependent of the former employee and elected continuation coverage because of event (A) listed under the Qualifying Events section of this provision; and
2. Social Security determines under Title II or Title XVI of the Social Security Act that the Covered Person is disabled within the first 60 days of coverage under the Cal-COBRA continuation.

For those Covered Persons, the 18-month maximum period of continued health coverage for qualifying event (A) may be extended 11 months for a total continuation period of 29 months. To obtain the extension, the Covered Person must notify the employer or KPIC of Social Security's determination within 60 days of the date of the determination letter and prior to the end of the original 18-month continuation of coverage period.

If Social Security subsequently determines that the Covered Person is no longer disabled, coverage will terminate on the later of:

1. the end of the original 18-month continuation of coverage period; or
2. the first day of the month that begins more than 31 days after Social Security determines the Covered Person is no longer disabled.

The Covered Person must notify the employer or KPIC that he or she is no longer disabled within 30 days of the date of Social Security determination.

For the continued health coverage of disabled Covered Persons that exceeds 18 months, KPIC may increase the Premium it charges by as much as 50%. The employer may require the disabled Covered Persons to pay all or part of that total increased premium.

Notice Requirements and Requests for Continuation Coverage

Notice of Event

You or Your Dependent must notify KPIC of the following qualifying events:

1. the death of the Covered Person;
2. Your legal divorce or legal separation from Your spouse or Domestic Partner;
3. Your child reaching the limiting age for a Dependent or otherwise becoming ineligible for coverage under the Group Policy;
4. Your becoming entitled to Medicare benefits under Title XVIII of the United States Social Security Act (Medicare).

The notice must be given to KPIC within 60 days after the date the event occurs. If You or Your Dependent fails to give KPIC notice within the 60-day period, You and Your Dependent ill not qualify for continuation of coverage under this Cal-COBRA provision. You or Your Dependent must also still send KPIC a written request for continuation of coverage within the time limits set forth below in the Request for Continuation of Coverage and Payment of Premium provision, below.

Notice Required of Employer

The employer must notify KPIC of the following events within 30 days of the date of the event:

1. The termination of the Insured Employee;
2. A reduction in hours of employment of the Insured Employee's employment;
3. The employer becoming subject to the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, as then constituted or later amended.

If the employer fails to provide KPIC with the required notice, KPIC will not be obligated to provide Cal-COBRA coverage to the affected Insured Employees or their enrolled Dependents.

Notice to You and Your Dependent of Right of Continuation

Within 14 days of receiving a notice of a qualifying event, KPIC will provide You or Your Dependent the necessary premium information, enrollment forms and disclosures needed to allow You or Your Dependent to formally make the election of continuation coverage.

Request for Continuation of Coverage and Payment of Premium

Continuation of coverage under the Group Policy must be requested in writing and be delivered to KPIC by first-class mail or other reliable means of delivery, including personal delivery, express mail or private courier, within the 60-day period following the later of:

A. The date the Covered Person's coverage under the Group Policy terminated or will terminate by reason of a qualifying event; or

B. The date the Covered Person was sent notice of the right to continuation of coverage.

Payment of the first Premium must be received by KPIC within 45 days of the date the Covered Person provided the written request to continue coverage under the Group Policy. The Premium must be sent by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier. The first Premium payment must equal an amount sufficient to pay all required Premiums and all Premiums due. If You or Your Dependent fails to submit the required Premium amount within the 45-day period, the You and Your Dependent will not be eligible for continuation coverage under Cal-COBRA.

Premiums will be due monthly and will not exceed 110 percent of the applicable rate charged for a Covered Person, or if the continuation is for a covered Dependent, not more than the 110 percent of the rate charged for a similarly situated Insured Dependent under the Policy. However, If the Covered Person is determined to be disabled under Title II or Title XVI of the United States Social Security Act, Premiums may be increased to up to 150 percent of the group rate after the first 18 months of continuation coverage.

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