

EMPLOYEE BENEFIT BOOKLET

COUNTY OF SAN BERNARDINO



deltadentalins.com

Group No: 18757

Effective Date: July 22, 2017

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INTRODUCTION

We are pleased to welcome you to the group dental plan for County of San Bernardino. Your plan is self-funded by your employer and your claims are administered by Delta Dental. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

This Employee Benefit Booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by Delta Dental of California ("Delta Dental") and cannot modify the Contract in any way.

Using This Employee Benefit Booklet

This Employee Benefit Booklet, which includes Attachment A, Deductibles, Maximums and Contract Benefit Levels (Attachment A) and Attachment B, Services, Limitations and Exclusions (Attachment B), discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Delta Dental. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with your employer, trust fund, or other entity ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This booklet is a summary of your group dental program and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

For more information please visit our website at deltadentalins.com or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 855-244-7323 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

*DELTA DENTAL OF CALIFORNIA
100 First Street
San Francisco, CA 94105*

DEFINITIONS

Terms when capitalized in your Employee Benefit Booklet have defined meanings, given in the section below or throughout the booklet sections.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: the amounts that Delta Dental will pay for covered dental services under the Contract.

Calendar Year: the 12 months of the year from January 1 through December 31.

Claim Form: the standard form used to file a claim or request Pre-Treatment Estimate.

Contract: the agreement between Delta Dental and the Contractholder, including any attachments.

Contract Benefit Level: the percentage of the Maximum Contract Allowance that Delta Dental will pay.

Contractholder: the employer group, the County of San Bernardino, herein referred to as the County whom is contracting to obtain Benefits.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Deductible: a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.

Delta Dental Premier[®] Provider (Premier Provider): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under a plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental Premier Contracted Fee: the fee for a Single Procedure covered under the Contract that a Premier Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental PPOSM Provider (PPO Provider): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee contracted fees as payment in full for covered services provided under a PPO dental plan. A PPO Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental PPO Contracted Fee: the fee for a Single Procedure covered under the contract that a PPO Provider has contractually agreed to accept as payment in full for covered services.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: the original date the Contract starts. This date is given on this booklet's cover and Attachment A.

Eligible Dependent: a dependent of an Eligible Employee eligible for Benefits as defined by the Contractholder.

Eligible Employee: any employee as eligible for Benefits as defined by the Contractholder.

Enrollee: an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Enrollee's Effective Date of Coverage: the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider's Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the Provider's Submitted Fee or the Program Allowance.

Non-Delta Dental Provider: a Provider who is not a PPO Provider or a Premier Provider and is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period: the month of the year during which employees may change coverage for the next Contract Year as defined by the Contractholder.

Patient Pays: Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

Pre-Treatment Estimate: an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee: an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee."

Procedure Code: the Current Dental Terminology[®] (CDT) number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental sets the Program Allowance for each procedure through a review of proprietary data by geographic area. The Program Allowance may vary by the type of network Dentist and/or the Program Allowance selected by the Contractholder at the time of application.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Qualifying Status Change: a change in accordance with the Contractholders Section 125 Plan Document.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Spouse: a person related to or a partner of the Primary Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; and
- as may be recognized by the Contractholder.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

EMPLOYEE PREMIUMS AND COUNTY CONTRIBUTIONS

The County helps you pay for your dental insurance by subsidizing your premiums through payments made directly to the carrier. The subsidy amounts vary and are based on your bargaining unit, family size, hire date, plan selection, and the number of hours you work. You are responsible for the cost of premium coverage which exceeds the County dental premium subsidy (DPS). For specific DPS amounts, refer to the appropriate MOU, Exempt Compensation Plan, Salary Ordinance, or Contract.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

The benefit must be offered to you through a MOU, Exempt Compensation Plan, Contract or Salary Ordinance.

Employee Eligibility

To be eligible for the benefits you must be:

- An employee in a regular position scheduled to work a minimum of 40 hours per pay period and have received pay for at least one half plus one hour of your scheduled hours (or be on an approved leave pursuant to applicable law).
- Your coverage begins on the first day of the pay period following the pay period in which premiums are first collected.
- Safety employees must be scheduled and paid for a minimum of 41 hours a pay period.

Dependent Eligibility

If an Eligible Employee participates in County-sponsored dental plans, the employee's eligible spouse, domestic partner or dependents may also participate if they meet one of the following criteria:

- Legal spouse or state-registered domestic partner
- Qualifying children which include children up to age 26 that are born to the employee, stepchildren, children legally adopted by the employee (including children legally placed in the employee's home while finalization of adoption is pending), children for whom the employee is the permanent legal guardian, children of a domestic partner and children the employee supports as a result of a valid court order.
- Qualifying children over the age of 26 incapable of self-sustaining employment by reason of total and permanent mental or physical disability as defined by the County's Section 125 Premium Conversion Plan document are also eligible for coverage.
- Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates, and relatives other than those listed above are not eligible for County-sponsored dental plans.

ENROLLMENT

- Eligible Employees must complete the enrollment process during the Open Enrollment Period in order to receive Benefits and for their Eligible Dependents to receive Benefits. Persons not originally eligible during the Open Enrollment Period may be enrolled mid-year as requested by the County.

Termination of Coverage

Employees

Your coverage will cease on the earliest date below:

- The last day of the Pay Period in which you have less than 41 hours of paid time.
- The last day for which you have made any required contribution for the insurance.
- The date the policy is canceled.

Dependents

Your coverage for all of your Dependents will cease on the earliest date below:

- The date your insurance ceases.
- The date you cease to be eligible for Dependent Insurance.
- The last day for which you have made any required contribution for the insurance.
- The date Dependent Insurance is canceled.

Your Dependents' coverage ends when yours does, or the pay period in which they are no longer eligible Dependents.

Continuation of Benefits

We will not pay for any services/treatment received after your coverage ends. However, we will pay for covered services incurred while you were eligible if the procedures were completed within 31 days of the date your coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Leave of Absence

Eligibility will be determined by the County in accordance with the County's Section 125 Premium Conversion Plan.

Continued Coverage under USERRA

Eligibility will be determined by the County in accordance with the County's Section 125 Premium Conversion Plan.

Continuation of Coverage Under COBRA

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. Contact your Human Resources Department at (909) 387-5787 for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the dental services described in Attachment B. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, are listed in Attachment A. If you receive dental services from a Provider outside the state of California, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in Attachment A and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that are discounted, waived or rebated.

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled "Selecting Your Provider" and "How Claims Are Paid" for more information.

Maximum Amount

Most dental programs have a maximum amount. A maximum amount (“Maximum Amount” or “Maximum”) is the maximum dollar amount we will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable is shown in Attachment A. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

Pre-Treatment Estimate

Pre-Treatment Estimate requests are not required, but are recommended as your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. 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 Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date you or your dependents coverage ends; or
- the date the Provider’s agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Coordination of Benefits

We coordinate the Benefits under the Contract with an Enrollee’s benefits under any other group or pre-paid plan or Benefit plan designed to fully integrate with other policies. If this plan is the “primary” plan, we will not reduce Benefits. If this plan is the “secondary” plan, we may reduce Benefits otherwise payable under the Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

- How do we determine which plan is the “primary” program?
 - (1) The plan covering you as an employee is primary over a plan covering you as a dependent.
 - (2) The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a) secondary to the plan covering the insured person as a dependent and
 - b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
 - (3) Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
 - a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but

- b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, 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) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.
- (5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).
- (6) The Benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. 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 is ignored.
- (7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
 - a) First, the Benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
 - b) Second, the Benefits under the continuation coverage.If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (8) If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the plan which covered you for the shorter term.
- (9) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore 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 Provider for your covered treatment, whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. In addition, you and your family members can see different Providers.

Remember, you enjoy the greatest Benefits—including out-of-pocket savings—when you choose a PPO Provider. To take full advantage of your dental plan, we highly recommend you verify a dentist's participation status with your dental office before each appointment. Review the section titled "How Claims Are Paid" 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 Delta Dental PPO Provider

There are two ways in which you can locate a PPO Provider near you:

- You may access information through our website at deltadentalins.com. This website includes a Provider search function allowing you to locate PPO Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at 855-244-7323 and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — PPO Provider

Payment for covered services performed for you by a PPO Provider is calculated based on the Maximum Contract Allowance. PPO Providers have agreed to accept the Delta Dental PPO Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A. Delta Dental's Payment is sent directly to the PPO Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Premier Provider

Payment for covered services performed for you by a Premier Provider is calculated based on the Maximum Contract Allowance. Premier Providers have agreed to accept the Delta Dental Premier Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A. Delta Dental's Payment is sent directly to the Premier Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Delta Dental Provider

Payment for services performed for you by a Non-Delta Dental Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A. Non-Delta Dental Providers have no agreement with Delta Dental and are free to bill you for any difference between what Delta Dental pays and the Submitted Fee.

When dental services are received from a Non-Delta Dental Provider, Delta Dental's Payment is sent directly to the Primary Enrollee. You are responsible for payment of the Non-Delta Dental Provider's Submitted Fee. Non-Delta Dental Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider yourself and then submit a claim to us for reimbursement. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A. Since our payment for services you receive may be less than the

Non-Delta Dental Provider's actual charges, your out-of-pocket cost may be significantly higher. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

How to Submit a Claim

Delta Dental does not require special claim forms. However, most dental offices have Claim Forms available. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

*DELTA DENTAL OF CALIFORNIA
P.O. Box 997330
Sacramento, CA 95899-7339*

CLAIMS APPEAL

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You and your Provider may also ask Delta Dental to examine any additional information provided that may support the appeal or grievance.

Send your appeal or grievance to us at the address shown below:

DELTA DENTAL OF CALIFORNIA
P.O. Box 997330
Sacramento, CA 95899-7339

We will send you a written acknowledgment within 5 days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. We will send the Enrollee a decision within 30 days after receipt of the Enrollee's appeal or grievance.

If the Enrollee believes he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us at our expense, in or near your community or residence. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to us within 12 months of the termination of the Contract.

Time of Payment

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify you and your Provider of any additional information needed to process the claim within this 30 day period.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you. All Benefits not paid to the Provider will be payable to you, the Primary Enrollee, or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by you or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the premium to reflect your actual circumstances at enrollment.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.

Attachment A
Deductibles, Maximums and Contract Benefit Levels

Contractholder: County of San Bernardino
Group Number: 18757 **Effective Date:** July 22, 2017

Deductibles & Maximums		
	Delta Dental PPOSM Provider	Delta Dental Premier[®] and Non-Delta Dental Providers
Annual Deductible	\$0	\$0
Annual Maximum	\$1,700 per Enrollee per Calendar Year	\$1,700 per Enrollee per Calendar Year
Annual Maximum waived for	Diagnostic and Preventive Services	
Orthodontic Maximum	\$1,700 per Enrollee per lifetime	\$1,700 per Enrollee per lifetime
Maximum Takeover Credit	Delta Dental will receive credit for any amount paid under the Contractholder's previous dental care plan, if applicable, for Orthodontic Services. These amounts will be credited towards the maximum amounts payable for Orthodontic Services.	
Contract Benefit Levels		
Dental Service Category	Delta Dental PPOSM Provider[†]	Delta Dental Premier[®] and Non-Delta Dental Providers[†]
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown in this table of the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services – Class II	100%	90%
Basic Services – Class VI	90%	90%
Major Services	75%	70%
Orthodontic Services	50%	50%

[†] Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.

Attachment B
Services, Limitations and Exclusions

Contractholder: County of San Bernardino

Group Number: 18757

Effective Date: July 22, 2017

Description of Dental Services

Delta Dental will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for the following services:

• **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
- (3) Palliative: emergency treatment to relieve pain.
- (4) Specialist Consultations: opinion or advice requested by a general dentist.

• **Basic Services – Class II**

- (1) Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care).
- (2) Endodontics: treatment of diseases and injuries of the tooth pulp.
- (3) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- (4) Denture Repairs: repair to partial or complete dentures, including rebase procedures, relining and adjustments.
- (5) Office Visit: office visit for observation – no other services performed.
- (6) Therapeutic Drug Injection: therapeutic parenteral drug.

- **Basic Services – Class VI**
 - (1) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
 - (2) Periodontics: treatment of gums and bones supporting teeth.
 - (3) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- **Major Services**
 - (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites; repairs of crowns, inlays/onlays.
 - (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair or recementation of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- **Orthodontic Services**
Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function; intraoral removable or fixed appliance therapy.
- **Note on additional Benefits during pregnancy**
When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing 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.

Limitations

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

Examples of Optional Services:

- a) a crown where a filling would restore the tooth;
- b) an inlay/onlay instead of an amalgam restoration;
- 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); or
- d) an overdenture instead of denture.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- (2) Exam and cleaning limitations
 - a) Delta Dental will pay for oral examinations (except after-hours exams and exams for observation) and cleanings no more than two (2) times in a Calendar Year.
 - b) A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided.
 - c) Note that periodontal cleanings, Procedure 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.
 - d) Caries risk assessments are allowed once in 36 months for Enrollees age three (3) to 19.
 - e) Delta Dental will pay for office visits no more than two (2) times in a calendar year.

- (3) X-ray limitations:
 - a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
 - d) A complete intraoral series is limited to once every five (5) calendar years. A panoramic film is limited to once every three (3) calendar years.
 - e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

- (4) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.

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

- (6) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

- (7) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime only when Orthodontic Services are covered. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.

- (8) Application of Sealants as a Benefit is limited to dependents up to age 14 through the completion of the procedure or the date eligibility terminates, whichever occurs first. Treatment with Sealants as a covered service is limited to application to posterior teeth. Applications to deciduous teeth or teeth with caries are not covered services. Sealants will be replaced only after two (2) calendar year have elapsed following any prior provision of such materials.

- (9) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.
- (10) Delta Dental will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated 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.
- (11) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (12) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16.
- (13) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- (14) Root canal therapy and pulpal 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.
- (15) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.
- (16) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- (18) Periodontal limitations:
 - a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.
 - b) Delta Dental will pay for periodontal prophylaxes (cleanings) no more than four (4) times in a Calendar Year.
 - c) 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 planing.
 - d) 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.
 - e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
 - f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
- (19) 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.

- (20) The following Oral Surgery procedure is limited to age 19 (or orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.
- (21) The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
- (22) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (23) Core buildup, including any pins, is covered not more than once in any 60 month period.
- (24) Post and core services are covered not more than once in any 60 month year period.
- (25) Crown repairs are covered not more than twice in any 60 month period.
- (26) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than twice in any 60 month period.
- (27) Prosthodontic appliances implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after five (5) calendar years have passed, except when Delta Dental 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 and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.
- (28) 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.
- (29) 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.
- (30) Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
 - a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.

- b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year 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.

(31) Limitations on Orthodontic Services

- a) The maximum amount payable for each Enrollee is shown in Attachment A.
- b) Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.
- c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
- d) Benefits are not paid for orthodontic retreatment procedures.
- e) Intraoral removable or fixed appliance therapy is limited to once per lifetime.

Exclusions

Delta Dental does not pay Benefits for:

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law , except as provided in Section 1373(a) of the California Health and Safety Code.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- (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, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

- (9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (11) laboratory processed crowns for Enrollees under age 12.
- (12) fixed bridges and removable partials for Enrollees under age 16.
- (13) interim implants and endodontic endosseous implant.
- (14) indirectly fabricated resin-based Inlays/Onlays.
- (15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, or tobacco counseling.
- (18) 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.
- (19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- (21) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (22) 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.
- (23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.
- (24) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
- (25) Missed and/or cancelled appointments.

Attachment C Wellness Benefits

Contractholder: County of San Bernardino
Group Number: 18757 **Effective Date:** July 22, 2017

Wellness Benefits are available to help improve the oral health of Enrollees with certain Qualifying Medical Conditions.

Qualifying Medical Conditions

Enrollees with one or more of the following Qualifying Medical Conditions will receive Wellness Benefits: cardiovascular (heart) disease; diabetes; cerebrovascular disease (stroke); HIV/AIDS and rheumatoid arthritis.

Wellness Benefits

The information in the table below replaces the coverage for routine cleanings, periodontal maintenance and periodontal scaling and root planing described in Attachments A and B.

Service	PPO Providers' Contract Benefit Level	Premier and Non-Delta Dental Providers' Contract Benefit Level	Limitations
Routine Cleaning & Periodontal Maintenance ¹	100%	100%	four (4) of the following (any combination) each Calendar Year - prophylaxis - periodontal maintenance - scaling in presence of moderate or severe gingival inflammation
Periodontal Scaling & Root Planing	100%	100%	once every Calendar Year per quadrant with no more than two (2) quadrants covered on the same date of service.

¹If an Enrollee is eligible for a pregnancy benefit and is also eligible for the Wellness Benefit, then Wellness Benefits replace the additional pregnancy benefits described in Attachment B, except such Enrollees will be entitled to one additional oral exam each Calendar Year while pregnant provided that written confirmation of the pregnancy is submitted.

All other Benefits, Limitations and Exclusions remain unchanged. Wellness Benefits are subject to applicable Deductibles and Maximums.

Signing up for Wellness Benefits

1. Go to deltadentalins.com.
2. Log in to your Online Services account. (If you don't have one, click Register.)
3. Click on the Optional Benefits tab in the left column.
4. Click on Opt In next to the name of the person you want to enroll. You can enroll yourself or a dependent child.
5. Complete and submit the form.