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 is your Certificate of Insurance (hereinafter Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Group Policy (hereinafter Policy). The Policy is issued to the UMB Bank (the Trust), situsedin the state of Missouri. The Trust Administrator is Kaiser Permanente Insurance Company (KPIC). The Policy is available for inspection by the Covered Person during normal business hours at KPIC's Home Office.

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 the Certificate are governed by the laws of the state in which the Group Policy was delivered. The Group Policy may be amended at any time without Your consent or prior notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

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. You may contact the Administrator at the following address:

Delta Dental of California
PO Box 997330
Sacramento, CA 95899

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 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.

For claims and benefit questions, contact our dental Customer Service Department at: 1-800-835-2244.

IMPORTANT NOTICE

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

Please refer to the Benefit and Limitations and Services Not Covered (Exclusions) section of this Certificate for a description of the plan's general limitations and exclusions. Likewise, the Table of Allowances contains specific limitations for specific benefits.

TABLE OF CONTENTS

The Sections of this Certificate Appear in the Order Listed Here

INTRODUCTION

How To Use This Certificate

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

GENERAL DEFINITIONS

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

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

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

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

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

Categories of benefits:

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

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

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

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

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

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

Dependent means only: a) Your spouse or Domestic Partner; and b) Your, Your spouse's, or Domestic Partner's child who is of an age within the age limits for Dependent children shown in the Table of Allowances. The word **"child"** includes: a) Your step-child; b) the child of Your son or daughter if Your son or daughter is an insured Dependent under the 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 Table of Allowances.

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

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

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

GENERAL DEFINITIONS

Eligible Person – the KFHP Individual Direct Pay Members and Eligible Dependents set forth under the ELIGIBILTY section of this Certificate, and persons ceasing to meet such conditions who elect continued coverage as provided under the CONTINUED COVERAGE OPTION section of this Certificate.

Insured – the Kaiser Foundation Health Plan (KFHP) Individual Direct Pay Member enrolled and insured under the Policy.

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

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

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

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

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

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

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

Usual, Customary and Reasonable (UCR):

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

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

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

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

ELIGIBILITY

KFHP Individual Direct Pay Members are eligible to enroll in this plan on the first day of the month coinciding with their enrollment under Kaiser Foundation Health Plan's Medical Plan(s) for Individual Direct Pay Members.

KFHP Individual Direct Pay Members shall have the option to enroll for coverage under the Policy under the following conditions:

a. KFHP Individual Direct Pay Members and their covered dependents may enroll only when first eligible or during an open enrollment period to be held not more than once annually.
b. If both spouses qualify as KFHP Individual Direct Pay Members, one spouse may enroll as a dependent of the other spouse, but dependent children may enroll for coverage under only one Individual Direct Pay Member.
c. KFHP Individual Direct Pay Members shall agree to pay the monthly Premium.
d. KFHP Individual Direct Pay Members who enroll agree to remain enrolled for a minimum of twelve (12) consecutive months. KFHP Individual Direct Pay Members who discontinue coverage shall not be allowed to re-enroll until the next open enrollment period.
e. Once a KFHP Individual Direct Pay Member elects to discontinue dependent coverage, dependents may not be re-enrolled under the Policy until the next annual open enrollment period, unless the dependent is the subject of a Qualified Medical Child Support Order requiring the KFHP Individual Direct Pay Member to provide the dependent Benefits under the Policy.

Eligible Dependents are the KFHP Direct Pay Member's spouse or domestic partner and Dependent children from 19 up to age 26. The Dependents of KFHP Direct Pay Members become Eligible Dependents on the same date that the KFHP Direct Pay Member, of whom they are a Dependent, becomes eligible for coverage under the Policy. Later-acquired Dependents become Eligible Dependents as soon as they acquire Dependent status.

A dependent, 26 years or older, may continue to be an Eligible Dependent and coverage will continue if they are incapable of self-sustaining employment by reason of mental or physical handicap and if they are chiefly dependent upon the KFHP Direct Pay Member for support and maintenance. Proof of such handicap or incapacity and dependency must be submitted at least thirty-one (31) days prior to the Dependent child attaining the limiting age of 26 years, and subsequently as may be required by KPIC or its Administrator. Neither KPIC nor its Administrator will request such proof more frequently than annually after the child in question has reached age 26.

Dependents in military service are not eligible.

Every KFHP Individual Direct Pay Member and his/her respective dependents meeting the preceding conditions of eligibility are eligible for coverage under the Policy. However, KPIC or its Administrator will not provide Benefits for any KFHP Individual Direct Pay Member or his/her respective dependents unless: (1) the KFHP Individual Direct Pay Member enrolls when first eligible or during an open enrollment period; and (2) the appropriate monthly Premium payment is made as required by this Certificate, for the months in which KPIC provides coverage for covered dental services.

A dependent's eligibility ends along with the KFHP Individual Direct Pay Member's eligibility, or sooner if the dependent loses his or her dependent status, unless continued coverage is chosen in a timely fashion by or on behalf of the dependent(s) under the CONTINUED COVERAGE OPTION section of this Certificate. Eligibility for such continued coverage will continue for the period required by the option. In any event, eligibility ends immediately when coverage under this Certificate or the Certificate under which this Certificate is issued ends.

ENROLLING IN THE DENTAL PLAN

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

You and Your dependent's enrollment under the Policy must parallel the enrollment in the Kaiser Foundation Health Plan's Medical Plan for Individual Direct Pay Members. This means that if You enrolled Your dependents as members under Kaiser Foundation Health Plan's Medical Plan, Your dependents must be enrolled under this dental insurance plan.

Dependent Enrollment

Eligible dependents are:

- Your spouse

- Your or Your spouse's unmarried dependent children age 19 up to age 26. Children include step-children, adopted children, children placed for adoption, and foster children provided they are dependent on Your for support and maintenance.

Payment Of Monthly Charges

Kaiser Foundation Health Plan, Inc. will bill the rate with their monthly medical rate.

The dental coverage described herein is not in effect until KPIC or its Administrator receives the Initial Premium from the Insured. The due date for subsequent Premium is the 10th day of each month. The Insured agrees to pay subsequent Premium no later than 31 days following the Premium due date, unless the Insured has given written notice requesting termination of dental coverage under the Policy in accordance with the Termination section of this Certificate. The Insured will be responsible for the payment of pro rata Premium for the time dental coverage under the Policy was in force during the 31-day grace period.

HOW THE PLAN WORKS

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

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

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

Deductible/Maximum

You pay the first $25 of Table of Allowance expenses to meet Your per person calendar year deductible, up to a Maximum of $75 for Your family. There is no deductible on diagnostic and preventive services. Your benefits cover a Maximum of $1,000 of dental services for each covered enrollee per calendar year.

Choosing Your Dentist

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

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

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

BENEFITS AND LIMITATIONS

This dental insurance plan covers the following benefits when they are provided by a licensed dentist and when necessary and customary by the standards of generally accepted dental practice.

I. Diagnostic and Preventive Benefits

Diagnostic:

- oral examinations;
- x-rays;
- diagnostic casts;
- biopsy/tissue examinations;
- emergency palliative treatment;
- specialist consultations.

Preventive:

- prophylaxis treatments (cleanings);
- space maintainers.

Limitations on Diagnostic and Preventive Benefits:

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

2) X-ray limitations:

   a) KPIC will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
   b) A complete intraoral series is limited to once every five (5) years.
   c) Bitewing x-rays are limited one (1) time in each calendar year for Enrollees 19 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

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

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

II. Basic Benefits

Oral surgery:	Extractions and certain other surgical procedures, including pre- and post-operative care
Restorative:	Amalgam, synthetic porcelain and plastic restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
Endodontic:	Treatment of the tooth pulp (root canal treatments)
Periodontic:	Treatment of gums and bones supporting the teeth
Sealants:	Protective coating for posterior molar (back) teeth
Emergency palliative treatment	Palliative (emergency) treatment of dental pain — minor procedure

Limitations on Basic Benefits:

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

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

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

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

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

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

7. Pin retention is covered not more than once in any 24 month period.

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

9. Periodontal limitations:

    a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.
    b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planning.
    c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, or ridge augmentation.

d) If in the same quadrant, scaling and root planing must be performed at least six weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider.
f) Periodontal cleanings Procedures Codes that include periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

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

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

III. Crowns, Jackets, Inlays, Onlays and Cast Restoration Benefits

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

Limitation on Crowns, Jackets, Inlays, Onlays and Cast Restoration Benefits

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

1) Crowns and onlays are limited to Enrollees age 19 and older and are covered not more than once in any five (5) year period except when KPIC determines the existing crown or onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experiences extensive loss or changes to tooth structure or supporting tissues.

2) When an alternate Benefit of an amalgam is allowed for inlays or porcelain/ceramic onlays, they are limited to Enrollees age 19 and older and are covered not more than once in any five (5) year period.

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

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

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

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

IV. Prosthodontic Benefits

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

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

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

2) Prosthodontic appliances that were provided under any KPIC program will be replaced only after five (5) years have passed, except when KPIC determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 19 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.

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

1) Made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.

    a) Denture rebase is limited to one (1) per arch in a 24 month period and includes any relining and adjustments for six (6) months following placement.
    b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a 12-month period and relining is limited to one (1) per arch in a six (6) month period.
    c) Tissue conditioning is limited to two (2) per arch in a 12 month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
    d) Recementation of fixed partial dentures is limited to once in a lifetime.

2) 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.

3) 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.

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

Examples of Optional Services:

a) A composite restoration instead of an amalgam restoration on posterior teeth;
b) A crown where a filling would restore the tooth;
c) An inlay or porcelain/ceramic onlay instead of an amalgam restoration; or
d) Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown.

NOTE: Note on additional Benefits during pregnancy:

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

SERVICES NOT COVERED (EXCLUSIONS)

I. Services Not Covered (Exclusions)

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

27. Provisional and/or temporary restorations except an interim removable partial denture is covered only to replace extracted anterior permanent teeth during the healing period.
28. Cosmetic surgery or procedures for purely cosmetic reasons.
29. Interim implants.
30. Indirectly fabricated resin-based inlays and onlays.
31. Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
32. Services or supplies covered by any other health plan of the Contract holder.
33. Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
34. 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.
35. Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
36. 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.
37. Procedures not shown on the Table of Allowances.

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

PREDETERMINATIONS

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

A Predetermination does not guarantee payment. It is an estimate of the amount KPIC will pay if You are eligible and meet all the requirements of the Policy at the time the treatment You have planned is completed.

In order to receive Predetermination, Your dentist must send an Attending Dentist's Statement to Us listing the proposed treatment. KPIC will send Your dentist a Notice of Predetermination which estimates how much of the treatment costs We will pay and how much You will have to pay. After You review the estimate with Your dentist and decide to go ahead with the treatment plan, Your dentist returns the statement to Us for payment when treatment has been completed.

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

Predetermining treatment helps prevent any misunderstanding about Your financial responsibilities. If You have any concerns about the Predetermination, let Us know before treatment begins so Your questions can be answered before You incur any charge.

CLAIMS PAYMENT AND APPEAL

Benefits, unless otherwise provided in this Certificate, are available from the Eligibility Date of the Eligible Person.

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

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

KPIC or KPIC Administrator will pay a Participating Dentist directly for covered dental services provided by that Dentist. CONTRACTS BETWEEN KPIC or KPIC'S ADMINISTRATOR AND ITS PARTICIPATING DENTISTS PROVIDE THAT, IN THE EVENT KPIC OR KPIC'S ADMINISTRATOR FAILS TO PAY THE DENTIST, THE INSURED WILL NOT OWE THE DENTIST FOR ANY SUMS OWED BY KPIC'S ADMINISTRATOR.

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

Written notice of the occurrence or commencement of covered services, treatment and supplies must be provided to KPIC within 20 days after such loss, or as soon as is reasonably possible. Written proof of such loss must be provided to KPIC within 90 days after such loss. Failure to provide such proof shall neither invalidate nor reduce any claim if it is not reasonably possible to furnish such proof within such time, provided such proof is provided as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. If a claim is denied because a Participating Dentist failed to make timely submission, the Insured does not owe that Dentist the amount which would have been payable by KPIC, provided that the Insured advised the Dentist of his or her eligibility for Benefits at the time of treatment.

KPIC will give each Participating Dentist, and any other Dentist or Eligible Person, not later than 15 days after such request, a standard form to make a claim for payment for services covered by this Certificate. In order to make a claim for payment, such form (completed by the Dentist who provided the services and by the Eligible Person or the patient's parent or guardian if such patient is a minor) must be submitted to KPIC's Administrator at the address on the form. If KPIC fails to provide a claim form within 15 days after such request, the person making such claim will be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting, within the time fixed above, written proof covering the occurrence, character and extent of the loss for which claim is made.

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

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

CLAIMS PAYMENT AND APPEAL

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

The Benefits which KPIC provides are limited to the applicable percentages of Dentist's fees or allowances specified in this Certificate. KPIC requires the Insured to pay the balance of any such fee or allowance, known as the "Patient Copayment", as a method of sharing the costs of providing dental Benefits between KPIC and the Insured. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Insured, KPIC only provides as Benefits the applicable percentages of the Dentist's fees or allowances reduced by the amount that such fees or allowances are discounted, waived or rebated.

OTHER OBLIGATIONS OF KPIC'S ADMINISTRATOR

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

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

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

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

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

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

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

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

KPIC's Administrator agrees to give the Insured a Certificate of Insurance summarizing the Benefits to which the Insured is entitled and other provisions of this Certificate. If an amendment to the Certificate materially affects any Benefits described in such Schedule, KPIC's Administrator will issue a corrected Schedule, rider or inserts.

IF YOU HAVE ADDITIONAL COVERAGE (COORDINATION OF BENEFITS)

COORDINATION OF BENEFITS:

This coordination of benefits (COB) provision applies to this plan when an insured or the insureds covered dependent has health care coverage under more than one (1) plan. Plan and this plan are defined here.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

a) Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
b) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is described in Section- Effect on the Benefits of This Plan.

DEFINITIONS:

A. **Plan** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
   1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
   2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Plans, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is a separate plan.

B. **This plan** is the part of the Trust Policy that provides benefits for dental care expenses.

C. **Primary plan/secondary plan**. The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two (2) plans covering the person, this plan may be a primary plan as to one (1) or more other plans and may be a secondary plan as to a different plan(s).

D. **Allowable expense** means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one (1) or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of that reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. **Claim determination period** means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or similar provision takes effect.

IF YOU HAVE ADDITIONAL COVERAGE (COORDINATION OF BENEFITS)

ORDER OF BENEFIT DETERMINATION RULES:

A. **General.** When there is a basis for a claim under this plan and another plan. This plan is a secondary plan which has its benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its benefits with those of this plan; and
2. Both those rules and this plan's rules require that this plan's benefits be determined before those of the other plan.

B. **Rules.** This plan determines its order of benefits using the first of the following rules which applies:

1. Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or Insured (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that -- if the 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 person as a dependent; and

   b. Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

2. Dependent child/parents not separated or divorced. Except as stated, 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 (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described previously 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.

3. Dependent child/separated or divorced. If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the plan of the parent with custody of the child;

   b. Then, the plan of the spouse of the parent with the custody of the child; and

   c. Finally, the plan of the parent not having custody of the child;

   d. If the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge; or

e. If the specific terms of a court degree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the **Order Of Benefit Determination Rules**.

4. Active/inactive employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a 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 (5) is ignored.

5. Continuation of coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

   a. First, the benefits of a plan covering the person as an employee, member or Insured (or as that person's dependent); and

   b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described here and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered an employee, member or Insured longer are determined before those of the plan which covered that person for the shorter term.

EFFECT ON THE BENEFITS OF THIS PLAN:

When This Section Applies: This section applies when, in accordance with **Order Of Benefit Determination Rules**, this plan is a secondary plan as to one (1) or more other plans. In that event the benefits of this plan may be reduced under this section.

Reduction in this plan's benefits: The benefits of this plan will be reduced when the sum of:

1. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and

2. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

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RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION:

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

IF YOU HAVE ADDITIONAL COVERAGE (COORDINATION OF BENEFITS)

FACILITY OF PAYMENT:

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

RIGHT OF RECOVERY:

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

A. The person it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

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

TERMINATION AND RENEWAL

Coverage described herein may be terminated for the following causes:

a. The Insured fails to remit Premium on or before its due date subject to the 31-day grace period.
b. By KPIC if the Policyholder fails: (1) to give KPIC or its Administrator, a list of all Enrolled Eligible Persons, as required under Article II; or (2) to permit the inspection of the Policyholder's records as called for under Article II, or (3) to pay Premiums as provided in Article III of the Policy, but only after the Policyholder has been duly notified of such failure (and billed for Premium, if applicable) and at least fifteen (15) days have elapsed since the date of notification.
c. By election of either the Policyholder or KPIC: (1) upon expiration of a Contract Term; or (2) during a Contract Term, if by mutual agreement.
d. By KPIC if the number of Enrolled Eligible Person reported by the Policyholder is less than ten (10) in each of three (3) consecutive months, but only if KPIC or its Administrator gives written notice not more than fifteen (15) days after it receives the list of Enrolled Eligible Persons which indicates that such grounds for termination exists. Termination is effective as of the last day of the month in which written notice if termination is given.

Such termination shall be without prejudice to any expense originating prior to the effective date of termination.

If KPIC or its Administrator terminates this coverage under (a) above, written notice will be provided to the Certificate Holder at least 31 days prior to the effective date of such action (or in the case of a Producer within 45 days of such action), all Benefits will end, and KPIC and its Administrator will be released from all further obligations of this Certificate as of the date indicated in the written notice. The Insured will remain liable to KPIC for the unpaid Premium applicable for the period this Certificate was in effect before termination.

If the Certificate Holder chooses to terminate this coverage at the end of a Contract Term, he or she must give at least thirty (30) days written notice of termination to KPIC's Administrator.

If KPIC or its Administrator wants to change the Premium or Benefits effective at the beginning of the next Contract Term, KPIC will give at least sixty (60) days advance written notice of such changes to the Insured. Such an advance notice will have the effect of a notice of termination as of the end of the Contract Term, unless the Insured agrees to the new provisions.

If the Insured notifies KPIC or its Administrator in writing of its intention to terminate this Certificate as of any date other than the end of the Contract Term, such notice will be treated as a failure to pay Premium, and such notice will constitute a waiver of the notification and billing required of KPIC or its Administrator under this Certificate.

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

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

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

If KPIC accepts the proper amount of Premium, after termination of this Certificate and without requiring a

new application, that acceptance will reinstate this Certificate as though never terminated, unless KPIC or its Administrator, within five (5) business days after it receives such payment, either: (1) refunds the payment so made; or (2) issues a new certificate accompanied by written notice stating clearly those respects in which the new certificate differs from the terminated certificate in Benefits, coverage, or otherwise.

All Benefits end for the Insured and his/her covered dependents when this Certificate ends, and KPIC will not provide continuation of Benefits to such persons in that event.

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

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

CONTINUED COVERAGE OPTION

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

a. Death of the Insured;

b. Divorce or legal separation from the Insured;

c. The Insured becoming entitled to Medicare benefits;

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

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

No agent has authority to change this Certificate or waive any of its provisions. No change in this Certificate is valid unless approved by an executive officer of KPIC and included in this Certificate by written amendment.

The provisions of this Certificate are severable. If any portion of this Certificate or any Amendment of it is determined to be illegal, void, or unenforceable by any court, or other competent authority, all other provisions of this Certificate will remain in effect.

The parties agree that all questions regarding the interpretation or enforcement of this Certificate are governed by the laws of the state in which the Policy was issued, where the Policy was entered into and is to be performed. Any provisions required to be in this Certificate by those laws bind KPIC whether or not stated in this Certificate.

KPIC and KPIC's Administrator agrees to consult each other to the extent reasonably practical concerning all materials published or distributed relating to this Certificate. Neither KPIC nor its Administrator will publish or distribute materials which are contrary to the terms of this Certificate.

KPIC agrees to permit and encourage the professional relationship between Dentist and patient to be maintained without interference.

All notifications required under this Certificate are fulfilled by directly notifying KPIC's Administrator. KPIC's Administrator for this insurance plan is:

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

Such notice will be effective forty-eight (48) hours after deposit in the United States mail with postage fully prepaid thereon.

Conditions Under which KPIC or its Administrator Will Provide Benefits

KPIC or its Administrator agrees to notify the Insured in writing within thirty (30) days of the receipt of a claim for loss if any services are denied coverage for Benefits, in whole or in part, stating the reason(s) for the denial.

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

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

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

KPIC Dental Insurance Plan
TABLE OF ALLOWANCES
(Maximum Amount Payable For Covered Dental Services*)

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

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

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

Code	Procedure	Allowance
D0602	Caries risk assessment and documentation, with finding of moderate risk	3.00
D0603	Caries risk assessment and documentation, with finding of high risk	3.00
D1000-D1999	**PREVENTIVE**	
Dental prophylaxis		
D1110	Prophylaxis – adult	43.20
D2000-D2999	**RESTORATIVE – Procedures subject to 6 month waiting period**	
Amalgam restorations (including polishing)		
D2140	Amalgam – one surface, primary or permanent	35.00
D2150	Amalgam – two surfaces, primary or permanent	43.00
D2160	Amalgam – three surfaces, primary or permanent	52.00
D2161	Amalgam – four or more surfaces, primary or permanent	58.00
Resin – based composite restorations – direct		
D2330	Resin-based composite – one surface, anterior	46.00
D2331	Resin-based composite – two surfaces, anterior	46.00
D2332	Resin-based composite – three surfaces, anterior	46.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	68.00
D2390	Resin-based composite crown, anterior	114.00
D2391	Resin-based composite – one surface, posterior	47.00
D2392	Resin-based composite – two surfaces, posterior	64.00
D2393	Resin-based composite – three surfaces, posterior	80.00
D2394	Resin-based composite – four or more surfaces, posterior	80.00
Inlay/onlay restorations		
D2510	Inlay – metallic – one surface	99.00
D2520	Inlay – metallic – two surfaces	133.00
D2530	Inlay – metallic – three or more surfaces	150.00
D2542	Onlay – metallic – two surfaces	191.00
D2543	Onlay – metallic – three surfaces	191.00
D2544	Onlay – metallic – four or more surfaces	191.00
D2650	Inlay – resin-based composite – one surface	34.00
D2651	Inlay – resin-based composite – two surfaces	50.00
D2652	Inlay – resin-based composite – three or more surfaces	63.00
D2662	Onlay – resin-based composite – two surfaces	50.00
D2663	Onlay – resin-based composite – three surfaces	63.00
D2664	Onlay – resin-based composite – four surfaces	63.00
Crowns – single restoration only		
D2710	Crown – resin-based composite (indirect)	80.00
D2712	Crown – ¾ resin-based composite (indirect)	80.00
D2720	Crown – resin with high noble metal	182.00
D2721	Crown – resin with predominantly base metal	163.00
D2722	Crown – resin with noble metal	177.00
D2740	Crown – porcelain/ceramic substrate	192.00
D2750	Crown – porcelain fused to high noble metal	182.00
D2751	Crown – porcelain fused to predominantly base metal	163.00
D2752	Crown – porcelain fused to noble metal	177.00
D2753	Crown – porcelain fused to titanium and titanium alloys	182.00
D2780	Crown – ¾ cast high noble metal	186.00
D2781	Crown – ¾ cast predominantly base metal	186.00

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

Code	Procedure	Allowance
D2782	Crown – ¾ cast noble metal	186.00
D2790	Crown – full cast high noble metal	183.00
D2791	Crown – full cast predominantly base metal	170.00
D2792	Crown – full cast noble metal	178.00
D2794	Crown – titanium	183.00
Other restorative services		
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	27.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	27.00
D2920	Re-cement or re-bond crown	27.00
D2921	Reattachment of tooth fragment, incisal edge or cups	51.00
D2931	Prefabricated stainless steel crown – permanent tooth	74.00
D2932	Prefabricated resin crown	80.00
D2933	Prefabricated stainless steel crown with resin window	90.00
D2950	Core buildup, including any pins when required	43.00
D2951	Pin Retention – per tooth, in addition to restoration	20.00
D2952	Post and core in addition to crown, indirectly fabricated	92.00
D2954	Prefabricated post and core in addition to crown	75.00
D2960	Labial veneer (resin laminate) – chairside	116.00
D2961	Labial veneer (resin laminate) – laboratory	128.00
D2962	Labial veneer (porcelain laminate) – laboratory	161.00
D2980	Crown repair - necessitated by restorative material failure	25.00
D3000-D3999 ENDODONTICS – Procedures subject to 6 month waiting period		
Pulpotomy		
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	38.00
D3221	Pulpal debridement primary/or permanent teeth	41.00
D3222	Partial pulpotomy – for apexogenesis - permanent tooth with incomplete root development	38.00
D3230	Pulpal therapy (resprbable filling)- anterior, primary tooth (excluding final restoration)	38.00
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	38.00
Endodontic therapy (including treatment plan, clinical procedures, and follow-up care)		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	193.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	227.00
D3330	Endodontic therapy, molar tooth (excluding final restoration)	306.00
D3333	Endodontic therapy, molar tooth (excluding final restoration)	56.00
Endodontic retreatment		
D3346	Re-treatment of previous root canal therapy – anterior	193.00
D3347	Re-treatment of previous root canal therapy – bicuspid	227.00
D3348	Re-treatment of previous root canal therapy – molar	306.00

KPIC Dental Insurance Plan
TABLE OF ALLOWANCES
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Code	Procedure	Allowance
D3351	Apexification/re-calcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	56.00
D3352	Apexification/re-calcification – interim medication replacement	56.00
D3353	Apexification/re-calcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	56.00
Apicoectomy/periradicular services		
D3410	Apicoectomy– anterior	240.00
D3421	Apicoectomy– bicuspid (first root)	257.00
D3425	Apicoectomy– molar (first root)	294.00
D3426	Apicoectomy (each additional root)	50.00
D3427	Periradicular surgery without apicoectomy	57.00
D3430	Retrograde filling – per root	57.00
D3450	Root amputation – per root	166.00
Other endodontic services		
D3920	Hemisection (including any root removal), not including root canal therapy	121.00
D4000-D4999 PERIODONTICS - Procedures subject to 6 month waiting period		
Surgical services (including usual postoperative services).		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	128.00
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces, per quadrant	77.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	77.00
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	159.00
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces, per quadrant	95.00
D4245	Apically positioned flap	159.00
D4249	Clinical crown lengthening – hard tissue	96.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	342.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces, per quadrant	205.00
D4263	Bone replacement graft – first site in quadrant	62.00
D4264	Bone replacement graft – each additional site in quadrant	47.00
D4266	Guided tissue regeneration – restorbable barrier, per site	135.00
D4267	Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)	135.00
D4268	Surgical revision procedure, per tooth	135.00
D4270	Pedicle soft tissue graft procedure	192.00
D4273	Subepithelial connective tissue graft procedures, per tooth	233.00
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	208.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	156.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	140.00

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Code	Procedure	Allowance
Non-surgical periodontal service		
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	59.00
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	35.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	36.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	43.00
Other periodontal services		
D4910	Periodontal maintenance	41.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	36.00
D5000-D5999 PROSTHODONTICS, REMOVABLE – procedures are subject to a 12 month waiting period		
Complete dentures (including routine post-delivery care)		
D5110	Complete denture – maxillary	240.00
D5120	Complete denture – mandibular	241.00
D5130	Immediate denture – maxillary	240.00
D5140	Immediate denture – mandibular	241.00
Partial dentures (including routine post-delivery care)		
D5211	Maxillary partial denture – resin base (including conventional clasps, rests and teeth)	203.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	212.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including conventional clasps, rests and teeth)	287.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including conventional clasps, rests and teeth)	287.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	216.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	216.00
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	120.00
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	120.00
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	108.00
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	108.00
Adjustments to dentures		
D5410	Adjust complete denture – maxillary	13.00
D5411	Adjust complete denture – mandibular	13.00
D5421	Adjust partial denture – maxillary	14.00
D5422	Adjust partial denture – mandibular	14.00
Repairs to complete dentures		
D5511	Repair broken complete denture base, mandibular	31.00
D5512	Repair broken complete denture base, maxillary	31.00
D5520	Replace missing or broken teeth – complete denture (each tooth)	25.00
Repairs to partial dentures		
D5611	Repair resin partial denture base, mandibular	30.00
D5612	Repair resin partial denture base, maxillary	30.00
D5621	Repair cast partial framework, mandibular	25.00
D5622	Repair cast partial framework, maxillary	25.00
D5630	Repair or replace broken clasp	36.00

KPIC Dental Insurance Plan
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Code	Procedure	Allowance
D5640	Replace broken teeth – per tooth	27.00
D5650	Add tooth to existing partial denture	31.00
D5660	Add clasp to existing partial denture	37.00
	Denture rebase procedures	
D5710	Rebase complete maxillary denture	94.00
D5711	Rebase complete mandibular denture	93.00
D5720	Rebase maxillary partial denture	89.00
D5721	Rebase mandibular partial denture	91.00
	Denture reline procedures	
D5730	Reline complete maxillary denture (chairside)	46.00
D5731	Reline complete mandibular denture (chairside)	45.00
D5740	Reline maxillary partial denture (chairside)	45.00
D5741	Reline mandibular partial denture (chairside)	47.00
D5750	Reline complete maxillary denture (laboratory)	70.00
D5751	Reline complete mandibular denture (laboratory)	70.00
D5760	Reline maxillary partial denture (laboratory)	71.00
D5761	Reline mandibular partial denture (laboratory)	71.00
	Interim prosthesis	
D5820	Interim partial denture (maxillary)	85.00
D5821	Interim partial denture (mandibular)	85.00
	Other removable prosthetic services	
D5850	Tissue conditioning, maxillary	25.00
D5851	Tissue conditioning, mandibular	24.00
D5863	Overdenture – complete maxillary	240.00
D5864	Overdenture – partial maxillary	287.00
D5865	Overdenture – complete mandibular	241.00
D5866	Overdenture – partial mandibular	287.00

D6200-D6999 PROSTHODONTICS, FIXED - Procedures subject to a 6 month waiting period
(Each retainer and each pontic constitutes a unit in a fixed partial denture.)

	Fixed partial denture pontics	
D6210	Pontic – cast high noble metal	171.00
D6211	Pontic – cast predominantly base metal	138.00
D6212	Pontic – cast noble metal	168.00
D6214	Pontic – titanium	171.00
D6240	Pontic – porcelain fused to high noble metal	176.00
D6241	Pontic – porcelain fused to predominantly base metal	155.00
D6242	Pontic – porcelain fused to noble metal	170.00
D6543	Pontic-porcelain fused to titanium and titanium alloys	170.00
D6250	Pontic – resin with high noble metal	176.00
D6251	Pontic – resin with predominantly base metal	155.00
D6252	Pontic – resin with noble metal	170.00
	Fixed partial denture retainers – inlays/onlays	
D6545	Retainer – cast metal for resin bonded fixed prosthesis	88.00
D6549	Resin Retainer- resin bonded fixed prosthesis	88.00
D6602	Retainer Inlay – cast high noble metal, two surfaces	121.00
D6603	Retainer Inlay – cast high noble metal, three or more surfaces	135.00
D6604	Retainer Inlay – cast predominantly base metal, two surfaces	121.00

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Code	Procedure	Allowance
D6605	Retainer Inlay – cast predominantly base metal, three or more surfaces	135.00
D6606	Retainer Inlay – cast noble metal, two surfaces	121.00
D6607	Retainer Inlay – cast noble metal, three or more surfaces	135.00
D6610	Retainer Onlay – cast high noble metal, two surfaces	288.00
D6611	Retainer Onlay – cast high noble metal, three or more surfaces	288.00
D6612	Retainer Onlay – cast predominantly base metal, two surfaces	288.00
D6613	Retainer Onlay – cast predominantly base metal, three or more surfaces	288.00
D6614	Retainer Onlay – cast noble metal, two surfaces	288.00
D6615	Retainer Onlay – cast noble metal, three or more surfaces	288.00
D6624	Retainer Inlay – titanium	135.00
D6634	Onlay – titanium	288.00
	Fixed partial denture retainers – crowns	
D6720	Retainer Crown – resin with high noble metal	181.00
D6721	Retainer Crown – resin with predominantly base metal	161.00
D6722	Retainer Crown – resin with noble metal	175.00
D6750	Retainer Crown – porcelain fused to high noble metal	181.00
D6751	Retainer Crown – porcelain fused to predominantly base metal	161.00
D6752	Retainer Crown – porcelain fused to noble metal	175.00
D6753	Retainer Crown – porcelain fused to titanium and titanium alloys	181.00
	Fixed partial denture retainers – crowns	
D6780	Retainer Crown – ¾ cast high noble metal	181.00
D6781	Retainer Crown – ¾ cast predominantly base metal	181.00
D6782	Retainer Crown – ¾ cast noble metal	181.00
D6790	Retainer Crown – full cast high noble metal	180.00
D6791	Retainer Crown – full cast predominantly base metal	159.00
D6792	Retainer Crown – full cast noble metal	175.00
D6794	Retainer Crown – titanium	180.00
	Other fixed partial denture services	
D6930	Re-cement or re-bond fixed partial denture	33.00
D6940	Stress breaker	38.00
D6980	Fixed partial denture repair necessitated by restorative material failure	50.00
	D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY Procedures subject to a 6 month waiting period	
	Extractions (includes local anesthesia, suturing, suturing, if needed, and routine postoperative care)	
D7111	Extraction, coronal remnants – deciduous tooth	20.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	39.00
	Surgical extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or section of tooth, and including elevation of mucoperiosteal flap if indicated	74.00
D7220	Removal of impacted tooth – soft tissue	90.00
D7230	Removal of impacted tooth – partially bony	117.00
D7240	Removal of impacted tooth – completely bony	134.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	78.00

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Code	Procedure	Allowance
Other surgical procedures		
D7260	Oroantral fistula closure	225.00
D7261	Primary closure of a sinus perforation	225.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	132.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	98.00
D7280	Surgical access of unerupted tooth	176.00
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	136.00
D7286	Incisional biopsy of oral tissue – soft	108.00
Alveoloplasty – surgical preparation of ridge for dentures		
D7310	Alveoloplasty in conjunction with extractions – per quadrant	59.00
D7311	Alveoloplasty in conjunction with extractions –one to three teeth or tooth spaces, per quadrant	36.00
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	96.00
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	58.00
Vestibuloplasty		
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	82.00
D7350	Vestibuloplasty – ridge extension (including soft tissue graft, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	218.00
Surgical excision of intra-osseous lesions		
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	131.00
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	273.00
Excision of bone tissue		
D7471	Removal of lateral exostosis (maxilla or mandible)	162.00
D7472	Removal of torus palatinus	162.00
D7473	Removal of torus mandibularis	162.00
Surgical incision		
D7510	Incision and drainage of abscess – intraoral soft tissue	48.00
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure not incidental to another procedure	115.00
D7970	Excision of hyperplastic tissue – per arch	88.00
D7971	Excision of pericoronal gingival	43.00
D9000-D9999 ADJUNCTIVE GENERAL SERVICES		
Unclassified treatment		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	41.00
Anesthesia		
D9222	Deep sedation/general anesthesia – first 15 minutes	36.00

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

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

IMPORTANT NOTICE

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

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

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

If You have a insurance complaint that cannot be satisfactorily resolved through a discussion or correspondence with KPIC, contact:

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

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

For California callers in all other area codes, call (800) 927-4357

Who Can Answer Your Questions?

For assistance with questions regarding Your coverage, such as Your benefits, Your current eligibility status, or name and address changes, please have your ID card available when You call:
Customer Services Department
1(800)-835-2244
Or You may write to:

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

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

www.deltadentalins.com