

SELF-FUNDED DENTAL Group Dental Benefits

FOR ELIGIBILITY REFER TO GENERAL INFORMATION SECTION

Dental Expense Benefits

If you or your dependent incur Covered Dental Charges, this plan will pay for the expenses actually incurred. Coverage cannot exceed the percentages of reasonable and customary covered charges as defined below for services, supplies and treatment itemized under Covered Dental Charge when performed by a legally qualified dentist for oral examinations and treatment of accidentally injured or diseased teeth and supporting bone or tissue.

REASONABLE AND CUSTOMARY COVERED CHARGES are those charges which do not exceed the customary fees charged by dentists for the same services performed within the particular geographic area or those charges which can be justified by the special circumstances of the particular case. You can however save by utilizing the First Dental Health Network.

First Dental Health

First Dental Health is the Preferred in Preferred Provider Organizations® Save Money and Stretch Your Benefit Dollar through the FDH PPO Network

Through Cupertino Union School District's self-funded dental plan you have access to substantial savings through the First Dental Health PPO Network. While the plan allows you to visit any dentist you choose, you save money when visiting those in the PPO Network.

The First Dental Health Network Offers:

DUAL SAVINGS

- Discounts on all procedures all the time (includes non-covered services, like orthodontia, teeth bleaching, implants, etc.)
- Discounts apply even after you've exceeded your plan's Annual Maximum
- No balance billing

ACCESSIBILITY

- Choose from over 15,950 PPO provider locations Statewide
- All offices open to new patients

QUALITY/PEACE OF MIND

- All FDH dentists are licensed, insured, and in good standing with the dental community.

Examples of In-Network Savings

For a Silver Filling (ADA Code #2150)	Charge*	Plan Pays	You Pay	You Save
Non-Network Dentist	\$177 (or	90% = \$159.30	10% = \$17.70	\$0
PPO dentist	more) \$82 (fixed)	90% = \$67.24	10% = \$8.20	\$9.50
For a Crown (ADA Code #2750)	Charge*	Plan Pays	You Pay	You Save
Non-Network Dentist	\$1098 (or	80% = \$878.40	10% = \$219.60	\$0
PPO dentist	more) \$852 (fixed)	90% = \$681.60	10% = \$170.40	\$49.20
For a Maxillary Partial Denture (ADA Code #5213)	Charge*	Plan Pays	You Pay	You Save
Non-Network Dentist	\$2019 (or	90% =	10% = \$403.80	\$0
PPO dentist	more) \$1236 (fixed)	\$1615.20 90% = \$988.80	10% = \$247.20	\$156.60

*Fees based off FDH Region 3

To find participating PPO dentists:

- ⇒ Go on-line for updates: www.fIRSTdentalhealth.com
- ⇒ Call FDH for assistance: (800) 334-7244
Customer Service is available Monday-Friday from 8am-5pm PST

IMPORTANT REMINDER: For information on participating dentists contact FDH. For information on claims, eligibility, and benefits contact United Administrative Services at (408) 288-4400.

Alternative Courses of Treatment

If alternate procedures, services or courses of treatment may be performed for the treatment of the injury or disease concerned or to accomplish the desired result, the amount included as Covered Dental Expense will not exceed the reasonable and customary charge for the least expensive procedure, service or course of treatment which, as determined by the administrator, will produce a professionally adequate result.

The benefits payable are subject to the definition, exclusions and notations in this booklet.

Calendar Year Deductible

All covered services are subject to a \$25 per person calendar year deductible up to a maximum of \$75 per family in each calendar year.

Covered Dental Charges

1. Covered Charges Payable at 100% for which the deductible is waived:
 - A. Oral examinations including cleaning of teeth but not more than two in any period of 12 consecutive months;
 - B. Topical Application of sodium or stannous fluoride, but only if the covered family member has not yet attained the age of 15 years;
 - C. Dental X-rays.
2. Covered Charges Payable at 90% of the UCR:
 - A. Extractions;
 - B. Oral surgery, including excision of impacted teeth;
 - C. Fillings;
 - D. General anesthetics administered in connection with oral surgery or other covered dental services;
 - E. Treatment of periodontal and other diseases of the gums and tissues of the mouth;
 - F. Endodontic treatment including root canal therapy;
 - G. Space maintainers;
 - H. Injection of antibiotic drugs by the attending dentist.
3. Covered Charges Payable at 80% of the UCR:
 - A. Inlays, gold fillings, crowns;
 - B. Precision attachments for dentures;
 - C. The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework provided that such work includes teeth extracted after the member's effective date in this or the previous plan;
 - D. Replacement of an existing partial or full removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the administrator is presented that:
 - 1) the replacement or addition of teeth is required to replace one or more natural teeth extracted while insured under the Plan; or
 - 2) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within 12 months from the date of installation of the immediate temporary denture.
 - E. Repair or recementing of crowns, inlays, bridgework or dentures, or relining

- of dentures;
 - F. The replacement of a crown restoration provided the original crown was installed more than five years prior to the replacement
 - G. Periodontal Recall (scaling and root planning) if performed by a Periodontist.
4. Covered Charges Payable at 50%:
- A. Orthodontic care, treatment, services and supplies (except for missing primary teeth), including correction of malocclusion. Orthodontia for adults was added as a benefit effective September 1, 2000.

Maximum Benefits

Benefits are payable up to \$1,500 per person lifetime maximum for orthodontics and up to \$2,000 per person each calendar year for all other covered charges.

Accident Benefit

This plan will pay 100% of covered charges for services rendered to sound natural teeth resulting from an accident and subject to a separate \$1,000 maximum per accident. Benefits must be used within one year from the date of the accident. This benefit is in addition to the \$2,000 maximum.

Coordination of Benefits

If you or an insured dependent are entitled to benefits under any other plan which will pay part of the expense incurred for necessary, reasonable and customary charges for treatment of a dental disease or injury, the amount of benefits payable under this plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred.

However, in no event will the amount of benefits paid under this plan exceed the amount, which would have been paid if there were no other plan involved.

How to File A Claim

1. Obtain a Claim Form from your school or at the District Office Human Resources.
2. Complete the employee portion of the claim form.
3. Have your dentist complete his/her portion of the claim form.
4. Upon completion of the claim form, attach itemized bills and return your claim form to:

CUSD Dental Plan
P.O. Box 5057
San Jose, CA 95150

If you have any questions regarding your claim, you may phone the administrator at:

(408) 288-4400

Should you desire a personal consultation, please bring all forms and bills, if any, to:

United Administrative Services
1120 South Bascom Avenue
San Jose, California 95128

Appointments are encouraged, and may be obtained by phoning the administrator at:

(408) 288-4400

How Claims Are Processed

Claim forms are available at your school or at the District Office Human Resources.

UAS and its dental consultant will review each claim for approval or adjustment. X-rays may be requested and approved by the UAS Dental Staff. After the claim is reviewed, and upon completion of the treatment, the employee will be reimbursed for the plan's share of the cost, provided benefits were not assigned; or the dentist providing treatment will be reimbursed for the plan's share of the cost.

Pre-Authorization of treatment is encouraged.

Claim Disputes

If an insured employee and/or his or her dentist disagree with plan benefits, the following system will be employed to provide satisfaction.

1. First, the claim, and the method of computing benefits, will be reviewed by dental consultants retained by the plan for correctness and suitability.
2. If, after a thorough review of circumstances, a dispute still exists between an employee and the plan:
 - A. The employer and plan will review - if a fee dispute - for a possible upward revision of UCR criteria; or
 - B. The claim may be submitted to peer review by the County Dental Association to determine suitability and/or necessity of treatment.

The plan agrees to abide by the findings of 1) or 2) above unless a dispute still exists. In that event, all parties shall agree to submit the claim to binding arbitration according to current California Civil Code.

Exclusions

1. Services for injuries or conditions which are compensable under Workers' Compensation or Employer's Liability Laws, services which are provided the eligible patient by any federal

or state government agency or are provided without cost to the eligible patient by any municipality, county or other political subdivision.

2. Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons.
3. Expenses incurred after termination of insurance except for prosthetic devices (including bridges and crowns) which were fitted and ordered prior to termination and which are delivered to you or your insured dependent within thirty days after the date of termination.
4. Prescribed drugs. (Refer to the CUSD Prudent Buyer Medical Plan or Kaiser.)
5. Hospitalization. (Refer to the CUSD Prudent Buyer Medical Plan or Kaiser.)
6. Facings on pontics or crowns posterior to the second bicuspid.

Limitations

The benefits as outlined are subject to the following limitations:

1. **X-rays** - Complete mouth X-rays are provided once in a three (3)-year period, unless special need is shown.
2. **Prophylaxis** - Prophylaxis (cleaning and scaling) including fluoride treatment for children is covered ONCE during any period of six (6) consecutive months.
3. **Prosthodontics** - Replacement will be made of an existing prosthodontic appliance only if it is unsatisfactory and cannot be made satisfactory. Prosthodontic appliances including partial and complete dentures, crowns, and bridges, will be replaced only after five (5) years have elapsed following any prior provision of such appliances.
4. **Optional Treatment** - In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the plan will pay the applicable percentage of the lesser fee. The patient is responsible for the remainder of the dentist's fee.
5. **Implants** - (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by this Plan. However, if implants are provided along with a covered prosthodontic appliance, the Plan will allow the prosthodontic appliances when the prosthetic appliance is completed. The Plan will not pay for any replacement for five (5) years following the completion of the services,

Further information may be obtained from:

UNITED ADMINISTRATIVE SERVICES
1120 South Bascom Avenue
San Jose, California 95128
Phone: (408) 288-4400

CLAIMS PROCEDURES

The Dental Plan provides that treatment or service must be medically necessary and be covered by your program. United Administrative Services has responsibility for determining whether claims are payable. A practicing dental-consultant retained by the claims administrator must agree if the denial is based on lack of medical necessity. To be considered medically necessary the treatment must be one that cannot be avoided without adversely affecting the patient's condition. The mere fact that your dentist orders the treatment does not mean that it is medically necessary.

No benefits are payable for care, treatment, services and supplies to the extent that they are not reasonably necessary for treatment of an injury or disease or to the extent that the charges for care, treatment, services or supplies are unreasonable.

APPEALS

An appeal of an adverse benefit determination is considered filed when a Claimant, or an authorized representative, submits a written request for review to:

Plan Administrator
United Administrative Services
P.O. Box 5057
San Jose, California 95150-5057

A request for review will be treated as received by the Plan (a) on the date it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

The Claimant must file an appeal of an adverse benefit determination within 180 days following the Claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment, the Claimant must submit an appeal within thirty (30) days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan as outlined above. This timing is without regard to whether all the necessary information accompanies the filing.

A Claimant may submit written comments, documents, records, and other information relating to the Claim. A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;
or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional. The health care professional engaged to review an appeal should be an individual who was neither the person consulted in connection with the adverse determination nor the subordinate of any such individual. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment . Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

The Plan's decision on review is the plan's final decision, subject to a Claimant's option to elect to submit a benefit dispute to the voluntary level of appeal through arbitration described below.

A Claimant has the right to bring a civil action if the Claimant has filed an appeal and the Claimant's request for coverage or benefits is denied following review and/or voluntary arbitration.

Voluntary appeals through arbitration

A Claimant may elect arbitration when an adverse benefit determination is upheld as explained in the section above, entitled "Appeals."

The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary level of appeal through arbitration provided by the Plan.

During arbitration, any statute of limitations or other defense based on timeliness is suspended during the time the voluntary appeal through arbitration is pending.

The Plan will provide to the Claimant, at no cost and upon request, sufficient information about arbitration to enable the claimant to make an informed judgment about whether to submit a benefit

dispute to arbitration. This information will include a statement that the decision will have no effect on the Claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the Claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the Claimant as part of the voluntary level of appeal, and the claimant will be told this. Arbitration is not mandatory.