

**Northern California General Teamsters Security Fund
PLAN E**

MEDICAL PLAN <i>Annual Deductible</i> <i>Annual Out-of-Pocket Maximum For Medical and Rx</i>	Anthem Blue Cross Prudent Buyer PPO Network \$1,300 per person / \$2,600 per family \$2,500 per person / \$5,000 per family for PPO Providers, then 100% for calendar year (combined with prescription drug.)	
Hospital Benefits <i>PPO Hospital</i> <i>Non-PPO Hospital</i> <i>Inpatient Mental Health/Substance Abuse</i> <i>Emergency Room</i> <i>Skilled Nursing Facility</i>	100% Inpatient & Outpatient after deductible 50% Inpatient & Outpatient after deductible 100% PPO / 50% Non-PPO, after deductible 100% after deductible 100% to a maximum of 120 days per disability period	
Medical Benefits* <i>PPO Providers</i> <i>Doctor Visits</i> <i>X-Ray and Lab</i> <i>Ambulance</i> <i>Surgeon & Related Services</i> <i>Outpatient Mental Health</i> <i>Alcohol & Substance Abuse</i> <i>Chiropractic</i> <i>Physical Therapy</i> <i>Hearing Aid / Testing</i> Preventive Care Benefits	80% after deductible, then 100% after out-of-pocket maximum is met. Payable as Medical* Payable as Medical* Payable as Medical* Payable as Medical* Payable as Medical* Payable as Medical* Payable as Medical* - \$1,500 calendar year maximum Payable as Medical* - 24 visits calendar year maximum Payable as Medical* - \$800 paid in 3 year period maximum 100% Benefit at PPO Providers; not subject to deductible No benefit at non-PPO providers	
<i>*Non-Contract Medical benefits are payable at 50% of usual, customary and reasonable allowance, unless emergency or otherwise indicated.</i>		
PRESCRIPTION DRUG PLAN <i>Retail & Mail – up to 100 day supply</i>	Generics: 80% after deductible; 100% after out-of-pocket is met Brand: 70% after deductible; 100% after out-of-pocket is met	
DENTAL PLANS <i>Deductible</i> <i>Percentage Payable*</i> <i>Maximum benefit per calendar year</i> <i>Orthodontia</i>	<i>(Dental Plan determined by CBA)</i>	
	Standard Plan No Deductible 80% Preventive 70% Restorative 50% Prosthodontic \$1,500 per person 70% up to \$1,000 lifetime max	Enhanced Plan No Deductible 80% Preventive 80% Restorative 80% Prosthodontic \$1,500 per person 70% up to \$1,000 lifetime max
DHMO Dental Plan	Premier Access DHMO No Deductible 100% of most services; no maximum 24 months of Orthodontic treatment, up to lifetime max of \$2,170	
VISION PLAN <i>Deductible</i> <i>Benefit Schedule</i>	Provided through Vision Service Plan \$10 Co-Pay per office visit Exams - 12 months Frames - 24 months Lenses - 24 months Contacts - 24 months in lieu of lenses/frames, \$150 in-network allowance	
EMPLOYEE LIFE	\$10,000 Basic plus \$10,000 AD&D	

This is a brief summary of benefits for illustrative purposes only. Please refer to the Plan's SPD for complete information.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.deltahealthsystems.com or by calling 1-800-417-8923.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$ 1,300 per person/\$2,600 per family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	\$ 0 (None)	You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,500 per person/\$5,000 per family, per calendar year for most expenses paid to in-network providers for medical and prescription drug combined. There is no OOP limit if you go to non-network providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Non-PPO coinsurance, premiums, balance-billed charges, penalties for not obtaining pre-authorization, drug copayments, certain services this plan does not cover.	Even though you pay these expenses they do not count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No	This plan will pay for medically necessary covered services with no lifetime or annual limits.
Does this plan use a <u>network of providers</u> ?	Yes. To locate a Blue Cross network provider, go to anthem.com/ca . For substance abuse treatment, TARP has its own provider list. Call TARP at 1-800-522-8277 for a list of providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, contract, PPO, preferred, or participating for <u>providers</u> in their <u>network</u> . See the chart starting on p. 2 for how this plan pays different providers.
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see specialists.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on p. 4. See your complete SPD for additional information about <u>excluded services</u> .

Questions: Call 1-800-417-8923 or visit us at www.deltahealthsystems.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.deltahealthsystems.com or call 1-800-422-6099 to request a copy. Covered Benefits are subject to Medical Necessity. * Benefits payable at PPO rates in cases of emergency; Otherwise at Usual, Customary and Reasonable (UCR) charges.

Northern California General Teamsters Security Fund: Plan E

Coverage Period: 01/01/17 to 12/31/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Family | Plan Type: PPO



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Blue Cross PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance (of UCR)*	Treatment must be medically necessary.
	Specialist visit	20% coinsurance	50% coinsurance (of UCR)*	Treatment must be medically necessary.
	Other practitioner office visit	20% coinsurance on visits to chiropractors, physical therapists, speech therapists, & occupational therapists.	50% coinsurance (of UCR)* on visits to chiropractors, physical therapists, speech therapists, & occupational therapists, and all charges exceeding annual limits.	Chiropractic services limited to \$1,500 per calendar year each. Physical, speech & occupational therapy limited to 24 visits each per calendar year. Treatment must be medically necessary.
	Preventive care/screening/immunization	No Charge	100% of billed amount (not covered out-of-network)	Covered at Anthem Blue Cross PPO providers only. Treatment must be recommended by U.S. Preventive Services Task Force.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance (of UCR)*	Treatment must be medically necessary.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance (of UCR)*	Treatment must be medically necessary.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mywdrx.com	Generic drugs	20% coinsurance per prescription.	You pay 100% of cost at pharmacy; reimbursable to in network pharmacy rates.	Up to 100 day supply retail or mail order. Medical necessity & some step therapies apply.
	Preferred brand drugs	30% coinsurance per prescription.	You pay 100% of cost at pharmacy; reimbursable at in network pharmacy rates.	Up to 100 day supply retail or mail order. Generics required when available. Medical necessity & some step therapies apply.
	Non-Preferred brand drugs	30% coinsurance per prescription.	You pay 100% of cost at pharmacy; reimbursable at in network pharmacy rates.	Up to 100 day supply retail or mail order. Generics required when available. Medical necessity & some step therapies apply.
	Specialty drugs	20% coinsurance per generic prescription; 30% coinsurance per brand prescription.	You pay 100% of cost (not covered at non-network pharmacies)	30 day supply. Generics required when available. Medical necessity & some step therapies apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	You pay 50% of charges up to \$3,000 and 100% of charges in excess of \$3,000	Must be medically necessary.
	Physician/surgeon fees	20% coinsurance	50% coinsurance (of UCR)*	Must be medically necessary.
If you need immediate medical attention	Emergency room services	No charge for facility; 20% coinsurance for professional services	No charge for facility; 20% coinsurance for professional services	Must involve a sudden onset of severe medical symptoms that could not have been reasonably anticipated and that require immediate medical treatment or that could be considered life-threatening.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be medically necessary.
	Urgent care	20% coinsurance	50% coinsurance (of UCR)*	Must be medically necessary.

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If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance (of UCR)*	Bariatric surgery covered at 80% with a maximum payment of \$20,000 at a Bariatric COE, inclusive of all charges (facility and professional). Organ transplants limited to one transplant per organ. Pre-authorization required or benefit reduced 20%. Must be medically necessary.
	Physician/surgeon fee	20% coinsurance	50% coinsurance (of UCR)*	Must be medically necessary.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance (of UCR)*	Must be medically necessary.
	Mental/Behavioral health inpatient services	No charge	50% coinsurance (of UCR)*	Must be medically necessary. Benefit reduced 20% if not preauthorized.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance (of UCR)*	Must be medically necessary. Preauthorization from TARP required.
	Substance use disorder inpatient services	No charge	50% coinsurance (of UCR)*	Must be medically necessary. Preauthorization from TARP required or benefit reduced 20%.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance (of UCR)*	Must be medically necessary.
	Delivery and all inpatient services	20% coinsurance for doctor/professional charges	50% coinsurance (of UCR)*	Must be medically necessary.

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Coverage for: Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance (of UCR)*	Benefit reduced by 20% if not preauthorized. Medical necessity required.
	Rehabilitation services	20% coinsurance	50% coinsurance (of UCR)*	Must be medically necessary.
	Habilitation services	20% coinsurance	50% coinsurance (of UCR)*	Must be medically necessary.
	Skilled nursing care	No charge	50% coinsurance (of UCR)*	Maximum 120 days per disability period. Benefit reduced by 20% if not preauthorized. Medical necessity req.
	Durable medical equipment	20% coinsurance	50% coinsurance (of UCR)*	Benefit reduced by 20% if charges over \$2,000 not preauthorized. Medical necessity req.
	Hospice service	20% coinsurance	100% of billed charges	Benefit reduced by 20% if not preauthorized.
If your child needs dental or eye care	Eye exam	VSP: No charge	VSP: Charges over \$50	VSP: One exam every 12 months
	Glasses	VSP: Charges exceeding \$150 for frames	VSP: Charges over \$70	VSP: One pair frames or contacts every 24 months; lenses every 12 months.
	Dental check-up	20% coinsurance	20% coinsurance (to UCR)*	One exam allowed every six months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
• Infertility treatment	• Treatment for sexual dysfunction	• Dietary control & nutritional counseling
• Cosmetic surgery	• Custodial (long-term) care	• Experimental treatments
• Acupuncture	• Private duty nursing	• Weight loss programs
• TMJ (with certain exceptions)	• Routine foot care	• Pregnancy of dependent daughters
• Charges for surrogacy pregnancy	• Elective abortion	

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|----------------------------|---|----------------|
| • Dental benefits (adult) | • Chiropractic services | • Hearing aids |
| • Routine eye care (adult) | • Bariatric surgery at a Blue Cross COE | |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights will be limited in duration and will require you to pay a premium, which may be substantially higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan administrator at: 1-800-417-8923. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323, ext. 61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Board of Trustees of the Northern California General Teamsters Security Fund, c/o Delta Health Systems, PO Box 1931, Stockton, CA 95201-1931; 1-800-417-8923.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 800-417-8923

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,460
- Patient pays \$2,080

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,300
Copays	\$0
Coinsurance	\$780
Limits or exclusions	\$0
Total	\$2,080

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,180
- Patient pays \$2,220

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,300
Copays	\$0
Coinsurance	\$770
Limits or exclusions	\$150
Total	\$2,220

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

DESCRIPTION	ADA code	DHMO 706 COPAY
Preventive Services		
Periodic Oral Exam	D0120	\$0
Comprehensive Exam	D0150	\$0
Full Mouth Series (FMX)	D0210	\$0
Panoramic	D0330	\$0
Periapical X-rays	D0220	\$0
Bitewings- four films	D0274	\$0
Adult Cleanings	D1110	\$0
Child Cleanings	D1120	\$0
Child Fluoride Treatment	D1203	\$0
Sealants 1st and 2nd Molars	D1351	\$0
Space Maintainers	D1510	\$0
Basic Services		
Restorations - Amalgam Fillings	D2161	\$0
Extractions - Erupted tooth	D7140	\$0
Surgical Removal - Erupted tooth	D7210	\$0
Root Canal Therapy - Anterior	D3310	\$0
Root Canal Therapy - Bi-cuspid	D3320	\$0
Root Canal Therapy - Molar	D3330	\$0
Scaling & Root Planing, per quadrant	D4341	\$0
Major Services		
Crowns	D2750	\$0
Bridges - per unit	D6210	\$0
Complete Denture - per arch	D5110	\$0
Partial Denture - per arch	D5211	\$0
Orthodontia (Child)	D8080	\$1970.00 †
(Adult)	D8090	\$2170.00 †

† based on 24 month treatment plan:
additional ortho co-pays may apply, see
Certificate of Insurance for full break down

Premier Access Dental provides you and your family with quality dental benefits at an affordable cost. The program is designed to encourage regular dentist visits to maintain oral health. When enrolling, you select a contracted dentist to provide services for you and your family. The size of a provider network is meaningless without the assurance of quality care. Our dental providers consist of dental facilities that have been carefully screened for quality.

Plan Benefit Highlights

- Additional Cleanings
- Defined Fees for Metal Upgrades
- Unlimited Benefits*

Why Choose Premier Access?

- A-Rated by AM Best
- Over 4000 Provider Access Points
- Over 20 years in the Managed Care Business

The Patient Charge Schedule is a summary of the covered services. Please check the Evidence of Coverage for full details. These services are covered only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Premier Access Dental is described in your plan documents. The benefits shown are performed as deemed appropriate by the attending Primary Care Dentist (PCD) subject to the limitations and exclusions of the program. Enrollees should discuss all treatment options with their PCD prior to services being rendered.

Our Member Services Department is available Monday thru Friday 8 a.m. to 6 p.m. to answer questions and provide any help you may need at 866.650.3660



* refer to your Evidence of Coverage for details

Exclusions and Limitations

The following dental Benefits are excluded:

1. Treatment which: a) is not included in the list of Covered Services; b) is not Dentally Necessary; or c) is Experimental or Investigational Service.
2. Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
3. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the policy.
4. Replacement of a lost or stolen appliance including but not limited to, full or partial dentures, space maintainers and crowns and bridges.
5. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions, unless specifically listed as a covered procedure on Schedule A.
6. Missed dental appointments. A fee of \$25 may be charged by your Primary Care Dentist for failure to cancel an appointment without 24 hours prior notification.
7. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
8. Treatment for a jaw fracture.
9. Services or supplies provided by a dentist, dental hygienist, dentist or doctor who is: a) a close relative or a person who ordinarily resides with You or an Eligible Dependent; b) an employee of the employer; c) the employer.
10. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
11. Services and supplies obtained while outside the United States, except for Emergency Care.
12. Services or supplies resulting from or in the course of your or your Eligible Dependent's regular occupation for pay or profit for which you or your Eligible Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify Us of all such benefits.
13. Any Charges which are:
 - a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and supplies.
 - b. Not imposed against the person or for which the person is not liable.
 - c. Reimbursable by Medicare Part A and Part B. If an Eligible Person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her Benefits under this policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for Eligible Persons insured under employers who notify Us that they employ 20 or more employees during the previous business year, this exclusion will not apply to an actively at work employee and/or his or her spouse who is age 65 or older if the employee elects coverage under this policy instead of coverage under Medicare.
14. Services and supplies provided primarily for cosmetic purposes, except as specified in Schedule A.
15. Services and supplies which may not reasonably be expected to successfully correct the Member's dental condition for a period of at least three years, as determined by Us.
16. Orthodontic services, supplies, appliances and orthodontic-related services, unless an orthodontic rider was included in the policy.
17. Extraction of asymptomatic, pathology-free third molars (wisdom teeth).
18. Therapeutic drug injection.
19. Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
20. General anesthesia or intravenous/conscious sedation, except as specified in Schedule A.
21. Excision of cysts and neoplasms, except as specified in Schedule A.
22. Osseous or muco-gingival surgery, except as specified in Schedule A.
23. Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes, except as specified in Schedule A.
24. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The covered charge for the services is based on the single dental procedure code that accurately represents the treatment performed.
25. Replacement of stayplates.
26. Dispensing of drugs not normally supplied in a dental office.
27. Malignancies.
28. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
29. The member will be responsible for the actual metal fees for any procedure involving the use of noble, high noble, or titanium metal.
30. Implant-supported dental appliances, implant placement, maintenance, removal and all other services associated with dental implants.
31. Dental services that are received in an Emergency Care setting for conditions which are not emergencies if the subscriber reasonably should have known that an Emergency Care situation did not exist.
32. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.

Limitations of Other Coverage:

1. This dental coverage is not designed to duplicate any Benefits to which Members are entitled under government programs, including CHAMPUS, Medi-Cal or Workers' Compensation. By executing an enrollment application, a Member agrees to complete and submit to the Plan such consents, releases, assignments, and other documents reasonably requested by the Plan or order to obtain or assure CHAMPUS or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.
2. Benefits provided by a pediatric dentist are limited to children under six years of age following an attempt by the assigned Primary Care Dentist to treat the child and upon Prior Authorization by Premier Access Dental, less applicable Copayments.

Diagnostic and Preventive Benefits Limitations

- Bitewing x-rays are now limited to two series within any 12-month period.
- Full mouth and panoramic x-rays are now limited to once every 3 years, unless medically necessary.
- Prophylaxis services (cleanings) are now limited to two per 12-month period.
- Dental sealants are now limited to children through the age of 15 years.

Restorative Dentistry

- Covered services now include posterior composite fillings.

Periodontics

- Periodontal maintenance is now limited to 2 treatments per 12 months.

Crown and Fixed Bridge

- The plan now covers treatment plans in excess of 5 units. There is an additional copayment of \$125 per unit for any treatment for 7 or more units.
- The plan covers porcelain restorations on posterior teeth for an additional copayment of \$75 per unit.

Prosthodontics

- The new plans include an exception to the 5 year replacement limitation to situations where there has been additional loss of natural functioning teeth.

