



SOUTHWEST CARPENTERS BENEFIT SCHEDULE

HOW DOES YOUR DENTAL PLAN WORK?

DENTAL BENEFIT PROVIDERS OF CALIFORNIA, INC ("DBP-CA") has created a plan that offers our members quality dental health services at a significant savings. We have contracted with quality, local dental professionals to provide services to you and your eligible dependents at no cost or for low fixed copayments. The following is an example of the potential savings on a typical case:

	PUD	Usual & Customary Fee
Office Exam & X-rays:	No Charge	\$45
Cleanings (2) - one every 6 months	No Charge	\$90

TAKE ADVANTAGE OF THE BENEFITS

In addition to substantial savings, there are many other advantages described in this brochure. Under this plan, there are no claim forms to complete, no deductibles and no yearly dollar maximum of coverage.

MEMBERSHIP ELIGIBILITY

This plan is for the employee and, if eligible, his/her family. Unless stated otherwise by your group, coverage is extended to the spouse and/or unmarried dependent children. Dependent children include: 1. All natural, 2. Adopted, 3. Step-children. An unmarried dependent child will be eligible to age 19, or age 23 if a full-time student. Automatic coverage is provided for mentally and/or physically challenged dependent children.

CHOOSE YOUR DENTIST AND OFFICE

You and your family choose your dentist from a wide network of private dental offices. A list of dental offices is provided to permit each member to choose the most convenient office. The member and dependents may select different dental offices. If so desired, you may transfer to a different Plan office. Simply notify the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

OTHER BENEFITS

Maximum benefits allowed annually per person are unlimited • No deductibles • No claim forms • You know your exact "out-of-pocket" costs, if any • You may select the participating dentist of your choice.

ENROLLMENT PROCEDURE

Fill out and return the enclosed enrollment form to your Benefits Administrator or return it to your Trust Fund Office. For more information call 800-999-3367.

OTHER CHARGES

The member pays the copayments listed on the Benefit Copayment Schedule for each procedure completed by the dentist. These fees must be paid directly to the participating dental office where treatment is received. Payments are due the day of service unless prior arrangements have been made with your dentist.

TERMINATION OF BENEFITS

1. On expiration date of dental coverage.
2. When dependent member gets married, attains the age of 19 or ceases to be a full-time student prior to age 23.
3. Permitting/committing fraud. In the event of termination, the Plan provider shall complete any procedures listed on the Benefit

Copayment Schedule commenced prior to the termination date, and the member is required to pay all copayments in accordance with the Benefit Copayment Schedule.

4. Members who violate the Plan's rules may have their benefits suspended or be transferred to an indemnity plan.

BASIC METHOD OF REIMBURSEMENT

The Plan contracts with general and specialized dentists to provide quality dental services for eligible group members. The Plan compensates its providers using direct reimbursement, discounted fee for service, fee for service and capitation. The Plan does not use provider incentives or bonus plans to influence specific dental care decisions.

SECOND OPINION

If the member has a treatment question or concern that cannot be addressed by the member's current Plan provider and/or Dental Director the member may request a second opinion from another Plan dentist. There is no cost for this second opinion except for applicable copayments, if any. The second opinion will be performed by a contracted Plan general dentist or specialist. A second opinion must be arranged through the Customer Service Department by calling 800-999-3367.

ACUTE CARE

The Plan is responsible for providing emergency dental services to our members immediately upon member enrollment in our plan. Emergency services subject to the limitations and exclusions found in your evidence of coverage.

BINDING ARBITRATION

In the event you are unable to utilize the "binding arbitration" provision contained in the contract because you believe it will cause you "extreme financial hardship," you may request financial assistance from the Plan. Eligible enrollees may request a copy of the Plan's written policy which includes information on how enrollees may request financial assistance in order to exercise all of their rights under this policy.

CONTINUITY OF CARE

You may have a qualified right to continue care with a previous provider for a designated period of time in some situations. PUD is in compliance with all state laws involving Continuity of Care Rights. A copy of the Plan's Continuity of Care policy is available upon request from Customer Service.

WHAT IS A "MANAGED CARE" DENTAL PLAN?

A "Managed Care" dental plan contracts directly with licensed dental professionals to deliver quality dental care to its members.

WHAT ARE THE BENEFITS?

PREVENTIVE: Exams, Cleaning, X-rays • **BASIC:** Fillings, Simple Extractions • **MAJOR:** Crowns, Molar Root Canal, Dentures, Bridges, Periodontic Surgery

HOW IS CARE RECEIVED?

The member may receive care by simply calling the selected dental location to schedule an appointment. There are no forms/cards required.

WHAT ABOUT MISSED APPOINTMENTS?

If a member fails to cancel an appointment at least 24 hours in advance, a "failed appointment fee" will be charged and no further appointments will be made until the cancellation fee is paid.

PRINCIPAL LIMITATIONS

Set forth below are the limitations that are applicable to this Plan:

1. Prophylaxis is limited to one treatment each 6-month period (including periodontal maintenance following active therapy).
2. Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a 5-year period from initial placement regardless of payor. Adjustments to crowns, bridges and dentures are included in the coverage for the appliance for the first 6 months after initial placement.
3. Partial dentures (including interim partial dentures, resin-based and metal-framework partial dentures) are not to be replaced within any 5-year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement to the existing partial is not feasible; an interim partial denture (D5820 or D5821) may be replaced with a covered partial denture (D5211, D5212, D5213 or D5214) no more than 1 time in a 5-year period from the placement of the interim partial denture (also known as "stayplate").
4. Denture relines are limited to one per denture (including immediate dentures) during any 12 consecutive months.
5. Replacement is provided for existing/partial denture/bridge only if it is unsatisfactory and cannot be made satisfactory by reline or repair.
6. The plan allows up to five units of crown or bridgework per arch within a 5-year period. Upon the sixth unit, the Plan considers the treatment to be full mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit within any 5-year period.
7. Non-surgical periodontal treatments (including but not limited to root planing/subgingival curettage) are limited to 4 quadrants during any 12 consecutive months. Surgical procedures are limited to one treatment per quadrant or area during any 36 consecutive months.
8. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period.
9. Bitewing x-rays: limited to one series in a 6-month period.
10. Full mouth x-rays and panoramic type films are limited to 1 set every 24 consecutive months. Full mouth x-ray is defined as a minimum of 6 periapical films plus bitewing x-rays.
11. Sealant benefits include application of sealants to permanent first/second molars and bicuspid with no decay, with no restorations and with the occlusal surface intact up to age 14. Sealant benefits do not include the repair or replacement of sealant on any tooth within 3 years of its application.
12. Single unit cast metal and/or ceramic restorations and crowns are covered only when the member is 17 years of age or older, and the tooth cannot be adequately restored with other restorative materials. Crown build-ups including pins are only allowable as a separate procedure in the exceptional instance where extensive tooth structure is lost and need for a substructure can be demonstrated by written report and x-rays. An allowance is made for pre-fabricated crown for children 16 and under.
13. Referral to a dental specialist (if covered) is limited to only those covered procedures that cannot be performed by a contracted general dentist, as determined by the Plan's Dental Director.
14. Third-molar ("wisdom teeth") extraction: limited to only those instances where the teeth cannot be treated in a more conservative manner.
15. Use of cosmetic materials; limited to anterior/posterior composite restorations (including composite restorations on facial surfaces of premolar teeth), and porcelain-fused-to-metal cast crown restorations on posterior teeth due to decay or fracture. All other cosmetic or esthetic care is excluded from coverage.
16. Plan benefits cast restoration using predominantly base metal. If the member requests noble/high noble metal be used (e.g., gold, semi-precious metals, etc.), the member may be charged a surcharge based on additional laboratory charges for such metals.
17. OPTIONAL DENTAL TREATMENT: Listed copayments apply for services ONLY when prescribed by a contracted dentist as a necessary, adequate and appropriate procedure for your dental condition. In some cases there may be more than one appropriate procedure/option to address a dental condition. Optional Dental Treatment defined as any procedure that is a dental laboratory upgrade of a standard covered service (members may be charged a surcharge based on additional laboratory costs); OR a more extensive covered service that is an alternative to an adequate, but more conservative, covered dental service. If a member selects a more extensive form of treatment than recommended by the contracted dentist or is alternative to an adequate, but more conservative covered dental service, the member may be charged the difference between the contracted dental office's usual fee for the more extensive form of treatment, and the usual fee for the covered treatment, plus the copayment for the covered benefit as listed in the benefit schedule.

PRINCIPAL EXCLUSIONS

The following dental procedures & services are not included in the Plan:

1. General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation and prescription drugs.
2. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable, or any other third-party is liable. Services provided to the enrollee by state government or agency thereof, or provided without cost to the enrollee by any municipality, county or other subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.
3. Benefits do not include splinting, hemisection, implants, overdentures, grafting (unless otherwise stated), guided tissue regeneration, all-ceramic cast restorations, precision attachments, duplicate dentures, and appliances for the treatment of bruxism.
4. Dental services and any related fees performed in a treatment facility other than the contracted provider's office (i.e. hospital, ambulatory care facility, outpatient clinic, surgical center, etc.)
5. Treatment of fractures and dislocations of the jaws.
6. Loss or theft of fixed/removable prosthetics (crowns, bridges, full or partial dentures) regardless of payor.
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress prior to Member's eligibility with the Plan (e.g.: teeth prepared for crowns, root canals in progress, fixed and removable prosthetics). Crowns, bridges or dentures started in one office (while under PUD coverage) are considered "in progress" until delivered. Additional benefits will not be provided for such treatment in progress.
8. The Schedule of Benefits of procedures is the definitive statement of coverage, and supersedes all other materials. Any service that is not specifically listed as a covered benefit is excluded, regardless of any other written material presented or implied.
9. Procedures, appliances/restorations to correct congenitally and/or developmentally missing teeth/other congenital and/or developmental

conditions, developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, anodontia) and supernumerary teeth.

10. Treatment/removal of malignancies, cysts, tumors or neoplasms.
11. Dispensing drugs not associated with a course of dental care, i.e.: medicinal irrigation, locally administered antibiotics and prescription drugs.
12. Crowns, bridges and/or dentures placed as definitive restoration of tooth structure lost as a result of accidental injury. Accidental injury is damage to hard/soft tissues of the oral cavity resulting from external forces to the mouth. Treatment for all accident-related services payable by another liability carrier, other than a dental plan. (Note: "Definitive" refers to a "final" or "permanent" appliance/treatment.)
13. Cases which in the professional opinion of the Plan's attending dentist or Dental Director are determined that satisfactory results cannot be obtained or where the prognosis is poor or guarded (i.e. without a minimum service expectancy of 3 years).
14. Dental services received from any dental office other than a Plan's dental office, unless expressly authorized in writing by the Plan or as cited under "Out of Area Emergency Treatment."
15. Removal of asymptomatic teeth, nonpathological teeth, extractions for orthodontic purposes; surgical orthognatic procedures and crown exposure with or without ligation.
16. Implant placement/removal, appliances placed on/services associated with implants, including but not limited to prophylaxis and periodontal treatment.
17. Crown lengthening procedures.
18. Replacement of long-standing missing tooth/teeth in an otherwise stable dentition. (e.g.: teeth missing 2 years or longer, not currently replaced, and where adjacent & opposing teeth are in occlusion).
19. Dental services and treatments for restoring tooth structure loss from abnormal/excessive wear or attrition, abrasion, abfraction, bruxism, and/or erosion, except when due to normal masticatory function; changing/restoring vertical dimension, or occlusion, and full mouth reconstruction, diagnosis and/or treatment of the temporomandibular joint (TMJ).
20. Dental services that cannot be performed in the Plan's general dental office because of physical, medical or behavioral limitations of eligible enrollees over the age of seven years.
21. Pathology reports are excluded from coverage.

CLAREMONT ORTHODONTIC BENEFITS PROVISIONS

a) \$1700 for a full-banded/2 year case, (Phase II treatment only), plus: \$200 for start-up fees; \$200 for one set of retainers (with retention limited to 12 consecutive months, if necessary) Member's payment schedule unless otherwise agreed upon between the member and the orthodontist: \$500 at inception of care (placement of bands); \$100 per month for 12 months. **b)** Benefit is available to each eligible member, spouse & dependent between ages 10 & 19. Not covered for dependent children over the age of 19. **c)** Treatment must be provided by a member of the orthodontic panel who is providing treatment under a contract with The Plan. Benefits cover 24 months of usual & customary Phase II treatment.

Should a member be terminated or become ineligible for benefits, the member is subject to the following provisions:

a) Benefits cease at loss of eligibility and/or group termination. If terminated while member and/or dependents have treatment in progress, member may complete treatment by paying the lesser of the following: 1) number of months remaining in treatment times \$125/month; 2) \$2200 less any copayments (including start-up fees) paid prior to termination of benefit. **b)** Group terminates benefit: the group reserves the right to assign members' residual obligation described in (a) above to successor organization. **c)** If member loses eligibility for 3 or more consecutive months they will be considered no longer eligible for benefits and (1) above applies. **d)** Dependents other than spouse lose benefits on the 19th birthday.

ADDITIONAL CHARGES

a) Treatment beyond 24 months is subject to office visit charge, and is the member's responsibility. **b)** Charge for each additional month will not exceed \$125 per month.

SERVICES NOT PROVIDED

a) Start-up including: 1. Cephalometric x-rays*; 2. Tracings*; 3. Study models*; 4. Photos*; **b)** Lost/broken appliances; **c)** Retreatment of ortho cases; **d)** Treatment in progress at inception of eligibility; **e)** Treatment changes necessitated by accident of any kind; **f)** Extraction of teeth/surgical procedures for ortho purposes; **g)** Replace (includes bridgework) or restore (includes crowns) teeth solely due to treatment; **h)** TMJ problems including assessment beyond that provided in general practice. **i)** Cases involving: 1. Surgical orthodontics; 2. Myofunctional therapy; 3. Cleft palate; 4. Micrognathia; 5. Macroglossia; 6. Hormonal imbalances; 7. Phase I ortho care; 8. Ortho care prior to age 10/after age 19. **j)** Transfer of ortho provider for any reason mid-treatment. **k)** Ortho cases extending beyond the 19th birthday are subject to loss of benefit residual obligation provision (refer to Section II Loss of Benefit/Residual Obligations). **l)** Any treatment rendered by non-contracted orthodontist.

* Start-up fees subject to additional combined charge not to exceed \$200.

GRIEVANCE PROCEDURE

Any complaints may be referred to the Plan's Customer Service Representative by calling 800-999-3367. Complaint forms and a copy of the grievance procedure are available from the Plan. The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-999-3367 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <<http://www.hmohelp.ca.gov>> has complaint forms, IMR application forms and instructions online. PACIFIC UNION DENTAL does not discriminate or tolerate discrimination of any kind against an enrollee who has filed a complaint with the Plan of any kind (i.e. against a provider or the Plan itself, or any other complaint). No Plan contract shall be cancelled because an enrollee filed a complaint with the Plan.

HOW TO USE YOUR PLAN?

General Dental Services: Please select a dental office from the list of contracted Plan Providers and indicate the dental office and ID# on the enrollment form. The Plan will assist you in selecting a dentist whenever you request such assistance. Thereafter, to obtain services, you need only contact the selected dental office and make an appointment. In the event you are dissatisfied with the dental office you selected, for any reason, and desire to transfer to another, you may do so by contacting the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

Specialty Services: Should your treatment plan require services of a specialist your dentist will refer you. All benefits and copayments apply to specialty services provided the referral has prior approval of the Plan's Dental Director. If you need assistance obtaining a specialty referral, please contact the Customer Service Department listed below.

Emergency Services/Urgent Care: Should you need urgent care or experience a dental emergency, contact your dentist and indicate that you need urgent/emergency care. If you need assistance obtaining emergency/urgent care from your dentist, or are out of the area, you may contact the Customer Service Department at 800-999-3367 during normal business hours to arrange for out-of-area emergency care.

After Hours Care: If you need services after hours, first contact your assigned dentist. Plan Providers are required to have 24-hour access to on-call care. If you are unable to contact your dental office, this plan provides for reimbursement for any emergency after-hours care out of the area up to \$100.00, less any usual copayments required for any procedures performed on a fee-for-service basis. If you need such care after-hours, you must notify the Plan within 48 hours of receiving care from a non-participating provider.

Out-of-Area Care: To receive dental care out of your area, first contact Customer Service Department at 800-999-3367 to determine if you can be served by another contracted Plan Provider. If you live more than 50

miles from a contracted Plan Provider, you may be directed to seek care from a non-Plan provider. If you need services after-hours, please refer to the above after hours care section.

For additional information call or write:

DENTAL BENEFIT PROVIDERS OF CALIFORNIA

800-229-3775 • 925-363-6000