Western Dental® & Orthodontics

Schedule of Covered Services

Individual Plan – Freedom Elite 1 Plan

Code	Description	Copayment
Diagnostic		
D0120	Periodic oral evaluation – established patient	0
D0140	Limited oral evaluation – problem focused	0
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	0
D0150	Comprehensive oral evaluation – new or established patient	0
D0160	Detailed and extensive oral evaluation – problem focused, by report	0
D0170	Re-evaluation limited, problem focused (established patient; not post-operative visit)	0
D0180	Comprehensive periodontal evaluation – new or established patient	0
D0210	Intraoral – complete series of radiographic images	0
D0220	Intraoral – periapical first radiographic image	0
D0230	Intraoral – periapical each additional radiographic image	0
D0240	Intraoral – occlusal radiographic image	0
D0250	Extraoral – first radiographic image	0
D0260	Extraoral – each additional radiographic image	0
D0270	Bitewing – single radiographic image	0
D0272	Bitewings – two radiographic images	0
D0273	Bitewings – three radiographic images	0
D0274	Bitewings – four radiographic images	0
D0277	Vertical bitewings – 7 to 8 radiographic images	0
D0330	Panoramic radiographic image	43
D0340	Cephalometric radiographic image	43
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0
D0351	3D photographic image	40
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	37
D0460	Pulp vitality test	37
D0470	Diagnostic casts	53
D0502	Other oral pathology	91
D0999	Unspecified diagnostic procedure	9
Preventive		
D1110	Prophylaxis – adult (limited to once per six months)	0
D1120	Prophylaxis – child (limited to once per six months)	0
D1203	Fluoride Treatment – Child	24
D1204	Fluoride Treatment – Adult	25
D1206	Topical application of fluoride varnish	20
D1208	Topical application of fluoride – excluding varnish	23
D1310	Nutrition counseling for the control of dental disease	0
D1320	Tobacco counseling for the control and prevention of oral disease	0
D1330	Oral hygiene instruction	0
D1351	Sealant – per tooth	10
D1352	Preventive resin restoration in moderate to high caries risk patient – permanent tooth	34
D1353	Sealant repair – per tooth	22
Space Maintainers		
D1510	Space maintainer – fixed unilateral	128
D1515	Space maintainer – fixed bilateral	180
D1520	Space maintainer – removable unilateral	127
D1525	Space maintainer – removable bilateral	150
D1550	Re-cement space maintainer	26
D1555	Removal of fixed space maintainer	46
Amalgam Restorations – Primary or Permanent		
D2140	Amalgam – one surface	25
D2150	Amalgam – two surfaces	35
D2160	Amalgam – three surfaces	45
D2161	Amalgam – four or more surfaces	70
Resin-Based Composite Restorations		
D2330	Resin-based composite – one surface	77
D2331	Resin-based composite – two surfaces	95
D2332	Resin-based composite – three surfaces	110
D2335	Resin-based composite – four or more surfaces or w/incisal edge (anterior)	182
D2390	Resin-based composite crown, anterior	72
D2391	Resin-based – one surface, posterior	95
D2392	Resin-based – two surfaces, posterior	130

D2393		Resin-based – three surfaces, posterior	160
Code		**Description**	**Copayment**
D2394		Resin-based – four or more surfaces, posterior	213
Crowns – Single Restoration Only			
** Additional charges. $75 for porcelain margin, $150 for porcelain on molars, $200 for high noble metal, $325 for specialized crowns such as Lava, Captek, Empress, Procera, etc. Copayments only apply when implant is performed by a participating general dentist.*			
D2510		Inlay – Metallic – one surface	245
D2520		Inlay – Metallic – two surfaces	275
D2530		Inlay – Metallic – three or more surfaces	320
D2542		Onlay – Metallic – two surfaces	413
D2543		Onlay – Metallic – three surfaces	432
D2544		Onlay – Metallic – four or more surfaces	300
D2610		Inlay – Porcelain/Ceramic – one surface	300
D2620		Inlay – Porcelain/Ceramic – two surfaces	315
D2630		Inlay – Porcelain/Ceramic – three or more surfaces	368
D2642		Onlay – Porcelain/Ceramic – two surfaces	350
D2643		Onlay – Porcelain/Ceramic – three surfaces	385
D2644		Onlay – Porcelain/Ceramic – four or more surfaces	432
D2650		Inlay – Resin-based composite – one surface	188
D2651		Inlay – Resin-based composite – two surfaces	238
D2652		Inlay – Resin-based composite – three or more surfaces	235
D2662		Onlay – Resin-based composite – two surfaces	204
D2663		Onlay – Resin-based composite – three surfaces	240
D2664		Onlay – Resin-based composite – four or more surfaces	280
D2710		Crown – Resin-based composite (indirect)	141
D2712		Crown – ¾ Resin-based composite (indirect)	156
D2720		Crown – Resin-based composite w/high noble metal	229
D2721		Crown – Resin-based composite w/predominantly base metal	211
D2722		Crown – Resin-based composite with noble metal	229
D2740	*	Crown – Porcelain/Ceramic substrate	345
	*	Crown – Zirconia (Lava)	350
D2750	*	Crown – Porcelain fused to high noble metal	300
D2751	*	Crown – Porcelain fused to base metal	273
Code		**Description**	**Copayment**
D2780	*	Crown – 3/4 cast high noble metal	251
D2781		Crown – 3/4 cast predominantly base metal	233
D2782		Crown – 3/4 cast noble metal	251
D2783		Crown – 3/4 porcelain/ceramic	286
D2790	*	Crown – Full cast high noble metal	300
D2791		Crown – Full cast predominantly base metal	362
D2792	*	Crown – Full cast noble metal	295
D2794	*	Crown – Titanium	496
D2799		Provisional crown	180
Other Restorative Services			
D2910		Re-cement or re-bond inlay, onlay, or partial coverage restoration	48
D2915		Re-cement or re-bond cast or prefabricated post and core	44
D2920		Re-cement or re-bond crown	25
D2921		Reattachment of tooth fragment, incisal edge or cusp	56
D2929		Prefabricated stainless porcelain crown – primary tooth	65
D2930		Prefabricated stainless steel crown – primary tooth	65
D2931		Prefabricated stainless steel crown – permanent tooth	65
D2932		Prefabricated resin crown	143
D2933		Prefabricated stainless steel crown with resin window	100
D2934		Prefabricated esthetic coated stainless steel crown – primary tooth	160
D2940		Protective restoration	39
D2941		Interim therapeutic restoration – primary dentition	59
D2949		Restorative foundation for an indirect restoration	36
D2950		Core buildup including any pins when required	90
D2951		Pin retention – per tooth in addition to restoration	26
D2952		Post and core in addition to crown, indirectly fabricated	100
D2953		Each additional indirectly fabricated post – same tooth	41

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Individual Plan – Freedom Elite 1 Plan

Code	Description	Copayment
D2954	Prefabricated post and core in addition to crown	144
D2955	Post removal	226
D2957	Each additional prefabricated post – same tooth	117
D2960	Labial veneer (resin laminate) – chairside	313
D2961	Labial veneer (resin laminate) – laboratory	401
D2962	Labial veneer (porcelain laminate) – laboratory	450
D2971	Additional procedure to construct new crown under existing partial denture framework	112
D2975	Coping	341
D2980	Crown repair	100
D2981	Inlay repair by report	85
D2982	Onlay repair by report	85
D2983	Veneer repair by report	85
D2990	Resin infiltration of incipient lesions	31
Endodontics		
D3110	Pulp cap – direct	41
D3120	Pulp cap – indirect	33
D3220	Therapeutic pulpotomy – removal of pulp coronal to the dentinocemental junction	95
D3221	Pulpal debridement, primary and permanent teeth	103
D3222	Partial pulpotomy for apexogensis	32
D3230	Pulpal therapy – anterior primary tooth	62
D3240	Pulpal therapy – posterior primary tooth	78
D3310	Endodontic therapy – anterior tooth	298
D3320	Endodontic therapy – bicuspid tooth	371
D3330	Endodontic therapy – molar	433
D3331	Treatment of root canal obstruction; non-surgical access	143
D3332	Incomplete endodontic therapy; inoperable; unrestorable or fractured tooth	366
D3333	Internal root repair of perforation defects	168
D3346	Retreatment of previous root canal therapy – anterior	340
D3347	Retreatment of previous root canal therapy – bicuspid	481
D3348	Retreatment of previous root canal therapy – molar	595
D3351	Apexification/recalcification – initial visit	195
D3352	Apexification /recalcification – interim medication replacement	88
D3353	Apexification/recalcification – final visit	269
D3357	Pulpal regeneration – completion of treatment	135
D3410	Apicoectomy – anterior	299
D3421	Apicoectomy – bicuspid (first root)	332
D3425	Apicoectomy – molar (first root)	377
D3426	Apicoectomy (each additional root)	207
D3430	Retrograde filling – per root	121
D3450	Root amputation – per root	146
D3920	Hemisection not including root canal therapy	192
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quandrant	310
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quandrant	149
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	120
D4230	Anatomical crown exposure – four or more contiguous teeth per quadrant	753
D4231	Anatomical crown exposure – one to three contiguous teeth per quadrant	359
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	425
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	256
D4249	Clinical crown lengthening – hard tissue	350
D4260	Osseous surgery – four or more contiguous teeth or tooth bounded spaces per quadrant	575
D4261	Osseous surgery – one to three contiguous teeth or tooth bounded spaces per quadrant	384
D4263	Bone replacement graft – first site in quadrant	254
D4264	Bone replacement graft – each additional site in quadrant	216
D4266	Guided tissue regeneration – resorbable barrier per site	261
D4268	Surgical revision procedure – per tooth	440
D4270	Pedicle soft tissue graft procedure	806
D4273	Subepithelial connective tissue graft procedure – per tooth	616

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D4274	Distal or proximal wedge procedure	559
D4275	Soft tissue allograft	741
D4276	Combined connective tissue and double pedicle graft	1105

Code	Description	Copayment
D4277	Soft tissue graft procedure – first tooth	523
D4278	Soft tissue graft procedure – each additional tooth	172
D4320	Provisional splinting – intracoronal	198
D4321	Provisional splinting – extracoronal	157
D4341	Periodontal scaling and root planning – four or more teeth per quadrant	60
D4342	Periodontal scaling and root planning – one to three teeth per quadrant	40
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	90
D4381	Localized delivery of antimicrobial agents	45
D4910	Periodontal maintenance	73
D4921	Gingival irrigation per quadrant	30
D4999	Unspecified periodontal procedure	67
Dentures		
D5110	Complete denture – maxillary	543
D5120	Complete denture – mandibular	543
D5130	Immediate denture – maxillary	580
D5140	Immediate denture – mandibular	580
D5211	Maxillary partial denture – resin base (including clasps and rests)	418
D5212	Mandibular partial denture – resin base (including clasps and rests)	434
D5213	Maxillary partial denture – cast metal with resin base	559
D5214	Mandibular partial denture – cast metal with resin base	559
D5225	Maxillary partial denture – flexible base	588
D5226	Mandibular partial denture – flexible base	610
D5281	Removable unilateral partial denture - on piece cast metal	220
Denture Adjustments and Repairs		
D5410	Adjust complete dentures – maxillary	47
D5411	Adjust complete dentures – mandibular	35
D5421	Adjust partial dentures – maxillary	35
D5422	Adjust partial dentures – mandibular	35
D5510	Repair broken complete denture base	77
D5520	Replace missing or broken teeth – complete denture	62
D5610	Repair resin denture base	76

Code	Description	Copayment
D5620	Repair cast framework	65
D5630	Repair or replace broken clasp	80
D5640	Replace broken teeth – per tooth	67
D5650	Add tooth to existing partial denture	82
D5660	Add clasp to existing partial denture	80
D5670	Replace all teeth and acrylic on cast metal framework – maxillary	447
D5671	Replace all teeth and acrylic on cast metal framework – mandibular	447
D5710	Rebase complete denture – maxillary	229
D5711	Rebase complete denture – mandibular	200
D5720	Rebase partial denture – maxillary	195
D5721	Rebase partial denture – mandibular	195
D5730	Reline complete denture – maxillary (chairside)	130
D5731	Reline complete denture – mandibular (chairside)	130
D5740	Reline partial denture – maxillary (chairside)	118
D5741	Reline partial denture – mandibular (chairside)	110
D5750	Reline complete denture – maxillary (laboratory)	175
D5751	Reline complete denture – mandibular (laboratory)	175
D5760	Reline partial denture – maxillary (laboratory)	160
D5761	Reline partial denture – mandibular (laboratory)	173
D5810	Interim complete denture – maxillary	215
D5811	Interim complete denture – mandibular	210
D5820	Interim partial denture – maxillary	227
D5821	Interim partial denture – mandibular	232
D5850	Tissue conditioning – maxillary	59
D5851	Tissue conditioning – mandibular	59
D5860	Overdenture – complete by report	108
D5862	Precision attachment by report	260
D5863	Overdenture complete – maxillary	789
D5864	Overdenture partial – maxillary	789
D5865	Overdenture complete – mandibular	789

D5866	Overdenture partial – mandibular	789
D5867	Replacement of replaceable part of semi-precision or precision attachment	131
D5875	Modification of removable prosthesis following implant surgery	180
D5982	Surgical stent	452

Code	Description	Copayment
Implants		
D6051	Interim abutment	180
D6052	Semi-precision attachment abutment	20.50
D6053	Implant/abutment supported full denture – arch (delivery)	626
D6061	Abutment supported porcelain fused to metal crown	925
D6062	Abutment supported cast high noble metal crown	902
D6063	Abutment supported cast metal crown – predominantly base metal	838
D6064	Abutment supported cast metal crown – noble metal	860
D6065	Implant supported porcelain/ceramic crown	836
D6066	Implant supported porcelain fused to titanium high noble metal crown	815
D6067	Implant supported titanium high noble metal crown	790
D6068	Abutment supported retainer for porcelain/ceramic FPD	950
D6069	Abutment supported retainer for porcelain fused to high noble metal FPD	1057
D6070	Abutment supported retainer for porcelain fused to base metal FPD	916
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	925
D6072	Abutment supported retainer for porcelain fused to cast metal FPD	913
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	869
D6074	Abutment supported retainer for cast metal FPD (noble metal)	903

Code	Description	Copayment
D6075	Implant supported retainer for ceramic FPD	941
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, high noble metal)	929
D6077	Implant supported retainer for cast metal FPD	893
D6080	Implant maintenance procedure	48
D6090	Repair implant supported prosthesis by report	287
D6091	Replacement of semi- or precision attachment – per attachment	208
D6092	Re-cement or re-bond implant/abutment supported crown	50
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	76
D6094	Abutment supported crown (titanium)	500
D6095	Repair implant abutment	208
D6100	Implant removal by report	261
D6101	Debridement of peri-implant defect	269
D6104	Bone graft at time of implant placement	277
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	932
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	932
D6112	Implant/abutment supported removable denture for partial edentulous arch – maxillary	932
D6113	Implant/abutment supported removable denture for partial edentulous arch - mandibular	932
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	3501
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	3501
D6116	Implant/abutment supported fixed denture for partial edentulous arch - maxillary	3501
D6117	Implant/abutment supported fixed denture for partial edentulous arch - mandibular	3501
D6194	Abutment supported retainer crown for FPD (titanium)	527
D6199	Unspecified implant procedure	196
Bridges		
D6205	Pontic – indirect resin based composite	170
D6210	Pontic – cast high noble metal	415
D6211	Pontic – cast predominantly base metal	326
D6212	Pontic – cast noble metal	397
D6214	Pontic – titanium	679

Code	Description	Copayment
D6240	Pontic – porcelain fused to high noble metal	417
D6241	Pontic – porcelain fused to predominantly base metal	371

D6242	Pontic – porcelain fused to high noble metal	408
D6245	Pontic – porcelain/ceramic	430
D6250	Pontic – resin with high noble metal	229
D6251	Pontic – resin with predominantly base metal	211
D6252	Pontic – resin with noble metal	238
D6253	Provisional pontic	284
D6545	Retainer – cast metal for resin bonded fixed prosthesis	316
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	202
D6549	Resin retainer for resin bonded fixed prosthesis	278
D6600	Inlay – porcelain/ceramic , two surfaces	501
D6601	Inlay – porcelain/ceramic, three or more surfaces	526
D6602	Inlay – cast high noble metal, two surfaces	267
D6603	Inlay – cast high noble metal, three or more surfaces	270
D6604	Inlay – cast predominantly base metal, two surfaces	245
D6605	Inlay – cast predominantly base metal, three or more surfaces	248
D6606	Inlay – cast noble metal, two surfaces	267
D6607	Inlay – cast noble metal, three or more surfaces	270
D6608	Onlay – porcelain/ceramic, two surfaces	282
D6609	Onlay – porcelain/ceramic, three or more surfaces	287
D6610	Onlay – cast high noble metal, two surfaces	269
D6611	Onlay – cast high noble metal, three or more surfaces	275
D6612	Onlay – cast predominantly base metal, two surfaces	247
D6613	Onlay – cast predominantly base metal, three or more surfaces	252
D6614	Onlay – cast noble metal, two surfaces	269
D6615	Onlay – cast noble metal, three or more surfaces	275
D6624	Inlay – titanium	245
D6634	Onlay - titanium	248
D6710	Crown – indirect resin based composite	170
D6720	Crown – resin with high noble metal	229
Code	**Description**	**Copayment**
D6721	Crown – resin with predominantly base metal	211
D6722	Crown – resin with noble metal	229

D6740		Crown – porcelain/ceramic	440
D6750	*	Crown – porcelain/ceramic fused high noble metal	300
D6751		Crown – porcelain/ceramic fused predominantly base metal	374
D6752		Crown – porcelain/ceramic fused noble metal	418
D6780		Crown – 3/4 cast high noble metal	647
D6781		Crown – 3/4 cast predominantly base metal	647
D6782		Crown – 3/4 cast noble metal	601
D6783		Crown – 3/4 porcelain/ceramic	311
D6790		Crown – full cast high noble metal	360
D6791		Crown – full cast predominantly base metal	345
D6792		Crown – full cast noble metal	397
D6793		Provisional retainer crown	272
D6794		Crown – titanium	496
D6930		Re-cement or re-bond fixed partial denture	50
D6940		Stress breaker	109
D6950		Precision attachment	208
D6980		Repair fixed bridge	75
D6985		Pediatric fixed partial denture	315
D6999		Unspecified fixed prosthodontic procedure	253
Oral Surgery			
D7111		Coronal remnants – primary teeth	58
D7140		Extraction – erupted tooth or exposed root	30
D7210		Surgical extraction	90
D7220		Removal of impacted tooth – soft tissue	138
D7230		Removal of impacted tooth – partially bony	186
D7240		Removal of impacted tooth – completely bony	216
D7241		Removal of impacted tooth – completely bony with unusual surgical complications	290
D7250		Surgical removal of residual tooth roots	130
D7251		Coronectomy – intentional partial tooth removal	218
D7260		Oroantral fistula closure	1279
D7261		Primary closure of a sinus perforation	533
D7270		Tooth reimplantion and/or stabilization of accidentally evulsed or displaced tooth	300
Code		**Description**	**Copayment**
D7280		Surgical access of an unerupted tooth	180
D7283		Placement of a device to facilitate eruption of an impacted tooth	220

Western Dental® & Orthodontics

Schedule of Covered Services

Individual Plan – Freedom Elite 1 Plan

D7285	Biopsy of oral tissue – hard	746
D7286	Biopsy of oral tissue – soft	320
D7288	Brush biopsy – transepithelial sample collection	195
D7310	Alveoloplasty with extractions – four or more teeth or tooth spaces per quadrant	132
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces per quadrant	120
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces per quadrant	180
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces per quadrant	160
D7472	Removal of torus palatinus	677
D7473	Removal of torus mandibularis	496
D7510	Incision and drainage of abscess – intraoral soft tissue	40
D7953	Bone replacement graft for ridge preservation – per site	279
D7960	Frenulectomy	207
D7963	Frenuloplasty	1179
D7970	Excision of hyperplastic tissue – per arch	196
D7971	Excision of pericoronal gingiva	175
D7972	Surgical reduction of fibrous tuberosity	1467
D7999	Unspecified oral surgery procedure	758
8000-8999	**See Orthodontic Benefits on the last Page**	
Other Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	57
D9120	Fixed partial denture sectioning	133
D9210	Local anesthesia not in conjunction with operative or surgical procedures	27
D9211	Regional block anesthesia	30
D9212	Trigeminal division block anesthesia	46
D9215	Local anesthesia in conjunction with operative or surgical procedures	22
D9219	Consultation – diagnostic services provided by a dentist or physician other than requesting dentist or physician	0

Code	Description	Copayment
D9230	Inhalation of nitrous oxide/anxiolysis analgesia	68
D9248	Non-intravenous conscious sedation	100
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	43
D9430	Office visit for observation - no other services performed	20
D9440	Office visit – after regularly scheduled hours	54
D9450	Case presentation, detailed and extensive treatment planning	0
D9630	Other drugs and/or medicaments, by report	20
D9910	Application of desensitizing medicament	104
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	137
D9920	Behavior management, by report	25
D9930	Treatment of complications – unusual circumstances	196
D9940	Occlusal guard, by report	208
D9942	Repair and/or reline of occlusal guard	55
D9950	Occlusion analysis – mounted case	32
D9952	Occlusal adjustment - complete	14
D9970	Enamel microabrasion	113
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	65
D9972	External bleaching – per arch	209
D9973	External bleaching – per tooth	194
D9974	Internal bleaching – per tooth	18
D9975	External bleaching for home application per arch	18
	Orthodontic Benefits	
D8070	Comprehensive orthodontic treatment of the transitional dentition (18-24 months of treatment)	4424
D8080	Comprehensive orthodontic treatment of the adolescent dentition (18-24 months of treatment)	4424
D8090	Comprehensive orthodontic treatment of the adult dentition (18-24 months)	4424

INDIVIDUAL SUBSCRIBER AGREEMENT AND EVIDENCE OF COVERAGE

DENTAL CARE PLAN ISSUED BY
WESTERN DENTAL SERVICES, INC.
P.O. BOX 14227
ORANGE, CA 92863
(800) 992-3366
Individual Plan

WELCOME TO WESTERN DENTAL

This Individual Subscriber Agreement and Evidence of Coverage (the "Agreement and Evidence of Coverage") will commence on the first day all of the following have occurred: the Plan has received the Prepayment Fee, the Subscriber has signed the Enrollment Form, and the Plan has approved the enrollment of the Subscriber and the Subscriber's Dependent(s), if any. This contract is executed in Orange, California and shall be construed under the laws of the State of California; and the parties hereto agree that any action relating to this contract shall be submitted to binding arbitration.

Please Note: It is your responsibility to determine whether the provider you use is a Participating Provider. If you are in doubt about the status of any provider or facility, call the Plan for verification.

The Plan welcomes Member participation on its Public Policy Committee, which meets quarterly at the Plan's corporate offices in Orange, California. In order to be considered for membership, please write or call the Plan's Member Services Department.

THE ENROLLMENT FORM AND THIS AGREEMENT AND EVIDENCE OF COVERAGE CONTAIN ALL OF THE TERMS AND CONDITIONS OF THE INDIVIDUAL MEMBERSHIP CONTRACT. YOU HAVE THE RIGHT TO REVIEW THIS AGREEMENT AND EVIDENCE OF COVERAGE COMPLETELY PRIOR TO ENROLLMENT.

THE ENROLLMENT FORM AND THIS AGREEMENT AND EVIDENCE OF COVERAGE SHOULD BE READ CAREFULLY AND COMPLETELY, AND INDIVIDUALS WITH SPECIAL DENTAL CARE NEEDS SHOULD READ CAREFULLY THOSE SECTIONS THAT APPLY TO THEM. YOUR SCHEDULE OF BENEFITS IS INCLUDED IN THIS PACKAGE.

YOU MAY CALL WESTERN DENTAL SERVICES, INC., AT 1-800-992-3366 FOR ADDITIONAL INFORMATION ABOUT YOUR BENEFITS. THE ENROLLMENT FORM INCLUDES A HEALTH BENEFITS MATRIX.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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I. DEFINITIONS

A. “Agreement and Evidence of Coverage” means this Individual Subscriber Agreement and Evidence of Coverage, including the accompanying Enrollment Form and Schedule of Benefits.

B. “Benefit Plan” means the specialized dental plan offered by Western Dental Services, Inc. pursuant to the requirements of the Knox-Keene Health Care Service Plan Act and regulations promulgated thereunder, and the terms and conditions of which are set forth in this Agreement and Evidence of Coverage.

C. "Copayment" means the fee charged to the Member by the Participating Provider, as described in this Agreement and Evidence of Coverage, including the Schedule of Benefits.

D. “Covered Services” means the dental services available under this Agreement and Evidence of Coverage.

E. "Dependent" means the spouse and children of a Subscriber, as defined herein under the section entitled Eligibility.

F. "Emergency Care" means services to diagnose and treat a dental condition, which is manifested by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate dental attention could reasonably be expected to result in any of the following:

1. Placing the health of the individual in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

G. “Enrollment Form” means the form signed by the Subscriber indicating his or her agreement to enroll in the Benefit Plan for one year and agreement to the terms and conditions of the Agreement and Evidence of Coverage, and designating the Subscriber’s Dependents who will be enrolled as Members of the Benefit Plan.

H. "Exclusion" means any provision of the Benefit Plan whereby coverage for a specified hazard or condition is entirely eliminated.

I. "Limitation" means any provision, other than an Exclusion, which restricts coverage under the Benefit Plan in which a Member is enrolled.

J. "Member" means a Subscriber or Dependent who meets the Plan’s eligibility requirements, is enrolled in the Benefit Plan, and for whom Prepayment Fees have been paid to the Plan. Wherever this Agreement and Evidence of Coverage creates a legal obligation on a Member, the Subscriber assumes the obligation for any Member who is a minor Dependent of the Subscriber.

K. "Participating Provider" means a dentist employed by the Plan to provide Covered Services to Members under this Benefit Plan.

L. "Plan" means Western Dental Services, Inc.

M. "Prepayment Fee" means the amount payable on a prepayment basis by the Subscriber to obtain benefits provided under the Agreement and Evidence of Coverage.

N. “Schedule of Benefits” means the list of Covered Services, and the authorized Copayment amounts under the Benefit Plan as set forth in this Agreement and Evidence of Coverage.

O. “Subscriber” means the individual enrolled in the Benefit Plan for whom the appropriate Prepayment Fee has been received by the Plan and whose signature appears on the Enrollment Form. Wherever this Agreement and Evidence of Coverage creates a legal obligation on a Member, the Subscriber assumes the obligation for any Member who is a minor Dependent of the Subscriber.

II. COMMENCEMENT DATE

To enroll yourself or a Dependent in the Benefit Plan for a one year term, please complete in full the enclosed Enrollment Form. List all eligible Dependents you wish to enroll and select a dental office where you wish to receive benefits from those dental offices on the enclosed list. Coverage for Subscribers and eligible Dependents shall commence on the first day all of the following have occurred: the Plan has received the Prepayment Fee, the Subscriber has signed the Enrollment Form, and the Plan has approved the enrollment of the Subscriber and the Subscriber’s Dependent(s), if any.

III. IDENTIFICATION CARD

The Plan issues each Member an identification card to be presented at the time that services are to be rendered by the Participating Provider.

IV. PREPAYMENT FEE

The Plan shall provide or arrange for the provision of the Covered Services specified in the Agreement and Evidence of Coverage. The Subscriber shall pay the Prepayment Fee set out in the Schedule of Benefits. The Prepayment Fee enrolls Members in the Benefit Plan for one year, and must be paid either at the time the Enrollment Form is submitted to the Plan.

V. ELIGIBILITY

A. The determination of who is eligible to participate and who is actually participating in the Benefit Plan shall be decided by the Plan. Any disputes or inquiries regarding eligibility, including rights regarding renewal, reinstatement and the like, if any, should be directed to the Plan.

B. The following provisions apply to Dependent coverage under the Benefit Plan.

1. Dependents include all newborn infants whose coverage shall commence from the moment of birth and all adopted, foster and step children whose coverage shall commence from the date of legal custody or placement. To continue coverage for these Dependents for more than 30 days, the Subscriber must pay any additional Prepayment Fee that applies within 30 days from the date of legal custody or placement.

2. Dependents shall also include all unmarried children under the age of 19 years who are chiefly dependent upon the Subscriber for their support. Eligibility shall be extended for full-time students under the age of 23 years, if unmarried and chiefly dependent upon the Subscriber for support.

3. Coverage shall not terminate while a dependent is and continues to be: (a) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and, (b) Chiefly dependent upon the Subscriber for support and maintenance

   At least ninety (90) days prior to a child reaching the limiting age, the Plan will send notice to the Subscriber that coverage for the dependent child will terminate at the limiting age unless proof of incapacity and dependency is provided within sixty (60) days of receipt of notice. The Plan shall determine if the child meets the conditions above, prior to the child reaching the age limit. Otherwise, coverage of the child will continue until the Plan makes its determination. After two (2) years following the child reaching the limiting age, the Plan may request proof of incapacity or dependency, but not more often than yearly.

   If you are enrolling a disabled or dependent child for new coverage, the Plan may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. The Subscriber must provide the Plan with the requested information within sixty (60) days of receipt of the request. The child must have been covered as a dependent of the Subscriber or spouse under a previous health plan at the time the child reached the age limit.

4. No person shall be eligible as a Dependent who is eligible as a Subscriber, nor may any person be an eligible Dependent of more than one Subscriber.

VI. BENEFITS

This Benefit Plan is intended to provide services that fall within the scope of general dentistry practice. General dentistry services are dental procedures that may be performed by a dentist who has not received advanced specialty training. Covered Services, including specialty services, shall be provided by a Participating Provider in a Western Dental Center. If a Member requires specialty services not available from a Participating Provider in the Member's assigned Western Dental Center, the Participating Provider will refer the Member to another Participating Provider who can provide the specialty service. In the event that a Participating Provider in the Member's assigned Western Dental Center or other local Western Dental Centers is not available to perform a particular specialty service, the Plan may refer the Member to a non-Participating Provider specialist based on the individual Member's medical and dental condition. In such cases where the

Member is referred to a non-Participating Provider, the service shall be treated as a Covered Service, and the same Prepayment Fee set forth in the Schedule of Benefits shall apply. If you require a specialty service, please ask the staff at your assigned Western Dental Center for the nearest Participating Provider that can provide that service. If you have a question regarding the availability of a specialist service at a particular Western Dental Center, please contact the Plan.

The Benefit Plan provides coverage of such services to Members as set forth in this Agreement and Evidence of Coverage, including the accompanying Schedule of Benefits, when services are obtained from a Participating Provider in a Western Dental Center. Such coverage will be provided when necessary for the dental health of a Member in accordance with professionally recognized standards of dental practice, subject to the Exclusions, Limitations, and other terms and conditions set out in this Agreement and Evidence of Coverage. The Schedule of Benefits establishes the Covered Services. Covered Services available without a Copayment are designated as "No Copayment" in the Schedule of Benefits. Covered Services are set forth in the Schedule of Benefits, together with the Copayment amounts.

The descriptive categories of Covered Services that correspond to the categories set forth in the Schedule of Benefits, together with references to Exclusions or Limitations specific to each category of services, follow. To locate the specific Covered Services of this Benefit Plan for a category of services described in the Agreement and Evidence of Coverage, refer to the corresponding category heading in the Schedule of Benefits. Additional Exclusions and Limitations are set forth in the "Exclusions" and "Limitations" Sections of this Agreement and Evidence of Coverage, which must also be consulted to determine the extent of Covered Services.

A. DIAGNOSTIC – Clinical examinations, radiographs, and other diagnostic tools used in conjunction with the Member's health history in order to evaluate necessary dental treatment. Clinical examinations may include the following:

1. Comprehensive Oral Evaluation – A comprehensive evaluation of a Member's dental health needs. This includes evaluating and recording a Member's dental and medical history and a general health assessment, including such things as dental caries, missing or un-erupted teeth, restorations, occlusal relationship, periodontal conditions (including periodontal charting), and hard and soft tissue anomalies.

2. Limited Oral Evaluation – An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Typically, Members receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

3. Periodic Oral Evaluation – An evaluation performed to determine any changes in a Member's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures.

   An initial visit shall include one of the following:
   - Comprehensive Oral Evaluation

- Limited Oral Evaluation

4. Radiographs/Diagnostic Imaging – Radiographs are primarily for clinical purposes; they represent an important diagnostic aide. A radiographic exam is a combination of periapical, bitewing, panoramic films or other views selected for a Member based on need. The number and type of radiographs in any examination will vary according to the needs of the Member, and will be provided as necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

B. **PREVENTIVE** – Those procedures that aid in the prevention of dental and oral disease. These may include the following:

1. Prophylaxis (Adult and Child) – These cleanings include scaling and polishing of the crown portion of exposed teeth in the mouth and is the treatment for the removal of stain, plaque, and calculus (tartar) above the gum line. It is not intended to be treatment for active periodontal disease where subgingival (beneath the gum line) scaling and root planing is usually required.

2. Topical Fluoride Treatment – Application of topical fluoride to aid in the prevention of caries formation.

3. Nutritional Counseling for Control of Dental Disease – Counseling on food selection and dietary habits as a part of the treatment and control of periodontal disease and caries.

4. Oral Hygiene Instruction – Instructions for home care. Examples include tooth brushing technique, flossing, and use of special oral hygiene aids.

   Exclusion: The Benefit Plan does not cover supplies used for oral hygiene and plaque control, such as dental floss, toothbrushes, tongue scrapers, fluoride products, toothpaste, mouth rinse, disclosing agents, and interproximal brushes.

5. Sealants – The application of sealants to pit and fissure areas as a measure in the prevention of caries.

6. Space Maintenance – passive appliances designed to prevent tooth movement.

C. **RESTORATIVE SERVICES** – Those procedures used to repair and restore the natural teeth to healthy condition.

1. Amalgam and Resin-Based Composite Restorations – Those procedures that include amalgam or resin-based composite restorative material used in order to repair and restore the natural teeth to healthy condition.

2. Crowns – Single Restoration Only – Those procedures that include gold, ceramic, porcelain and porcelain fused to metal in covering the tooth.

   Exclusions:

a) Crowns that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered.
b) Implant supported crowns and abutment supported crowns on a dental implant are not a Covered Service.

3. Other Restorative Services –

a) Re-cementation of crowns – Use of adhesive material to reattach a crown that is dislodged.
b) Prefabricated Stainless Steel and Resin Crowns
c) Sedative filling – Temporary restoration intended to relieve pain.
d) Post and core buildup – Material placed within the root canal or in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.
e) Labial Veneer (Porcelain Laminate) – A thin layer of porcelain or ceramic restoration that is bonded to the facial surface (the surface of a tooth oriented toward the face) of a tooth by means of a resin adhesive.

D. ENDODONTICS – Those procedures that involve treatment of the pulp, root canal and roots.

1. Pulp Capping – Procedure in which exposed or nearly exposed pulp is covered with a dressing that protects the pulp and promotes healing and repair.
2. Pulpotomy – Removal of a portion of the pulp to maintain the vitality of the remaining portion by means of a dressing.
3. Root Canal Therapy – The treatment of diseases and injuries of pulp and the root canal, and placement of the root canal filling.
4. Apicoectomy – A surgical procedure to repair the damages to the root surface. Apicoectomy is a Covered Service only when specifically identified in the Schedule of Benefits.

Exclusions:

1. Apexification/Recalcification – Procedures that result in the closure of the tip of the root end (apex) in preparation for a final root canal filling on a tooth with perforated or open apex are not covered.
2. Hemisection – Separation of a multirooted tooth into separate sections containing the root and the overlying crown is not covered.
3. Retrograde filling – Sealing and filling the root canal from the root end (apex) is not covered.

All endodontic services that are not specifically identified in the Schedule of Benefits are not covered.

Limitation:

Endodontic services that are beyond the scope of general dentistry practice are not Covered Services. Examples include, without limitation, root canal treatment of teeth

with dilacerated roots, calcified canals, obstructed canals, open apices, and external or internal root resorption.

E. PERIODONTICS– Those procedures that involve the treatment of the gum and bone supporting the teeth and the management of gingivitis (gum inflammation) and periodontitis (gum disease).

1. Periodontal Services (Surgical). The following Periodontal Services (Surgical) are Covered Services if performed by a Participating Provider.

   a) Gingivectomy – Removal of part of the gingival margin resulting in exposure of more tooth structure.
   b) Crown Lengthening – Surgical procedure involving the removal of gingiva and supporting bone to expose more tooth structure in preparation for a crown procedure.

   Exclusions:

   a) Osseous Surgery – Surgical procedures involving the reshaping of the bone are not covered.
   b) Bone Graft – The Benefit Plan does not cover any form of graft used to stimulate bone formation.
   c) Soft Tissue Graft – Gingival grafts to repair gingival defects or exposed roots are not covered.
   d) Tissue Regeneration – Use of biologic material to aid in soft and bony tissue regeneration in repairing periodontal defects is not covered.)

   All surgical periodontal services that are not specifically identified in the Schedule of Benefits are not covered.

   Limitations:

   Treatment, evaluation, and planning for periodontal services that are beyond the scope of general dentistry are not covered.

2. Periodontal Services (Non-surgical)

   a) Scaling and Root Planing - Instrumentation of the crown and root surface of the teeth to remove plaque, calculus (tartar), and contaminated connective tissue from these surfaces.
   b) Full Mouth Debridement – Removal of plaque and calculus that obstruct the ability to perform an evaluation.
   c) Provisional Splinting (extracoronal) – An interim stabilization of mobile teeth.
   d) Periodontal Maintenance – Maintenance of periodontal health of patients who have undergone active surgical or nonsurgical periodontal therapy.
   e) Emergency Periodontal Treatment – Treatment provided to treat acute pain of periodontal origin.

f) Localized Delivery of Chemotherapeutic Agents – Use of controlled release chemotherapeutic agents as an adjunctive procedure for reduction of subgingival flora.

Limitation:

Treatment, evaluation, and planning for periodontal services that are beyond the scope of general dentistry are not covered.

F. PROSTHODONTICS, REMOVABLE– Replacement of lost teeth by a removable prosthesis and the maintenance of those appliances.

1. Complete and Partial Dentures – Full or partial dentures are a Covered Service when dentures are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

Exclusions:

a) Appliances lost, stolen, or damaged due to Member abuse are not covered.
b) Implant supported prostheses are not covered.

Limitation:

Overdentures (a denture that overlies, and is supported by, a retained tooth root or a dental implant) are not covered unless specifically listed in the attached Schedule of Benefits.

2. Tooth Additions and Repair to Existing Dentures – When required because of loss of natural teeth, tooth addition to existing dentures is covered by the Plan. Replacement of missing or broken denture teeth, and repairs to the denture base are also covered.

Limitation: Repair of appliances damaged due to Member abuse is not covered.

3. Denture Reline and Rebase – The process of refitting a denture by resurfacing the tissue side of the denture, or by replacing the base material of the denture. Relining and rebasing existing dentures are also Covered Services.

4. Interim Prosthesis – A provisional prosthesis designed for use over a limited period of time, after which it will be replaced by a more definitive restoration. If a Member receives an interim partial or interim complete denture while a permanent prosthetic appliance is being made, the Member will only be charged the Copayment for the permanent prosthetic appliance according to the accompanying Schedule of Benefits.

5. Precision Attachment: A set of male and female components used in the fabrication of removable partial dentures.

6. Tissue conditioning: Treatment relines using materials designed to heal unhealthy ridges prior to more definitive final restoration.

7. Valplast: A laboratory processed removable partial appliance constructed of flexible resin.

G. PROSTHODONTICS, FIXED (Fixed Partial Dentures or Bridges)– Replacement of lost teeth by fixed prosthesis is a Covered Service.

1. Fixed Partial Denture Pontics (an artificial tooth on the Fixed Partial Denture) and Abutment Crowns (an artificial crown made to support a Fixed Partial Denture, and which is attached to the Fixed Partial Denture Pontic via a retainer) used in the fabrication process of Fixed Partial Dentures are Covered

Services.

Exclusions:

a) Replacement or repair of fixed partial dentures that are lost, stolen, or damaged due to Member abuse is not covered.
b) Distal extension posterior cantilever pontics, which are supported at the front end only, are not covered.
c) Implant supported prostheses are not covered.
d) Correction of Occlusion or "occlusal equilibration" when performed independently of a completed restoration of a prosthesis may be recommended to treat temporomandibular joint disorders (TMJ) or myofacial pain. In such instances, correction of occlusion is not covered, since this Benefit Plan does not cover treatments of disturbances of the TMJ.

2. Fixed Partial Denture Services –

a) Recementation of Fixed Partial Dentures – Use of adhesive material to reattach a bridge that is dislodged.
b) Post and Core Buildup – Material placed within the root canal or in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.
c) Stress Breaker: Non-rigid connector between the abutment and the pontic.

H. ORAL SURGERY – Those procedures that involve the extraction of teeth and other surgical procedures as listed in the attached Schedule of Benefits. Oral Surgery procedures not specifically identified in the Schedule of Benefits are not covered.

1. Extractions – Removal of teeth or parts of teeth.

Limitation:

Extraction of third molars that is beyond the scope of general practice dentistry due to actual or potential unusual surgical complications from factors such as inferior alveolar nerve proximity, high probability of maxillary sinus exposure, and aberrant tooth position is not covered.

2. Other Surgical Procedures. The following Oral Surgery procedures are Covered Services if performed by a Participating Provider specifically identified in the Schedule of Benefits.

a) Biopsy (Soft Tissue) – The process of removing tissue for histologic evaluation.
b) Tuberosity Reduction – The process of reshaping of the posterior portion of the maxillary alveolar ridge.
c) Removal of Tori and Exostosis – The process of removal of overgrown bony protuberances.
d) Intraoral Incision and Drainage (I & D) – The process of drainage of an abscess through an incision.

e) Frenectomy – The process of elimination of muscle fibers attaching the cheek, lips, and tongue to associated dental mucosa.
f) Excision of Hyperplastic Tissue – The process of removing overgrown soft tissue from the oral cavity.
g) Alveoloplasty – Reshaping the bond supporting a dental prosthesis.

Exclusions:

a) Vestibuloplasty – Surgical procedures to increase relative alveolar ridge height are not covered.
b) Treatment of fractures of the upper or lower jaw bone is not covered.
c) Excision of benign or displastic (malignant) soft tissue or bony lesions is not covered.
d) Surgical exposure of impacted or unerupted tooth to aid eruption is not covered.
e) All surgical procedures that are not specifically identified in the Schedule of Benefits are not covered.

Limitation:

Surgical procedures that are beyond the scope of general dentistry practice are not covered.

I. ORTHODONTICS (Braces) – The Plan's orthodontic benefit covers basic orthodontic treatment to improve alignment of the teeth, establish optimal interdigitation of the upper and lower teeth, and improve the functional and esthetic relationships of the teeth and jaw, and may involve transitional, adolescent, and adult dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan. Orthodontic treatment is covered for the Copayments set out in the Schedule of Benefits, subject to the Exclusions and Limitations described in this Agreement and Evidence of Coverage. Copayments will vary according to the length of treatment and the appropriate stage of dental development.

The following services are not included in the orthodontic treatment Copayment.

1. Services Required Because of Gross Non-Cooperation - Additional orthodontic services required because Member's cooperation does not meet the minimum level necessary to complete the treatment adequately, or is damaging to the teeth, are not included in the orthodontic treatment Copayments. Failure to attend required appointments, failure to maintain proper oral hygiene, and failure to wear appliances as instructed by the Participating Provider are examples of gross non-cooperation for which the Member would be subject to additional charges that will not be covered by the orthodontic treatment Copayments. (These are examples, not a complete list. Any gross non-cooperation that adversely affects the outcome of orthodontic care or extends the overall length of treatment beyond the original intended treatment plan may subject the Member to additional charges).

Should treatment extend beyond the original estimated treatment time due to Member's non-compliance, Member will be subject to an office visit Copayment for each additional office visit necessary until orthodontic care is completed. Each such office visit Copayment will equal the result obtained by dividing Member's total original orthodontic treatment Copayment divided by the number of months in the original treatment plan.

2. Lost, Stolen, Damaged or Broken Appliances - Replacement of damaged or lost retainers, brackets, bands, wires or other materials supplied by the orthodontist is not included in the orthodontic treatment Copayments.

3. Removable Orthodontic Appliance Therapy - The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth is not included in the orthodontic treatment Copayments. Examples include, but are not limited to: Bionator, Schwartz Appliance, Herbst Appliance, positioner, headgear, and retainers (without braces). Please see the Schedule of Benefits for a complete list of covered removable orthodontic appliances.

Orthodontic Limitations and Exclusions

The following services are not covered under the Benefit Plan:

1. Extractions for Orthodontic purposes – Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space is not covered.

2. TMJ/Myofunctional Therapy -Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture are not covered.

3. Surgical Orthodontics - Surgical Orthodontics to reposition the jawbones and teeth is not covered.

4. Treatment of Cleft Palate - Treatment for problems involving holes or voids in the bone that forms the roof of the mouth is not covered.

5. Orthognathic Surgery- Surgery to move the jawbones into alignment is not covered.

6. Treatment of Hormonal Imbalances - The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage is not covered.

7. Class III Orthodontics - Treatment for problems with the growth relationship of the upper and lower jaw resulting in positioning of the lower jaw or teeth in front of the upper jaw or teeth is not covered.

8. Orthodontic Treatment Commenced Prior to Coverage - An orthodontic treatment program which commenced before the Member enrolled in this Benefit Plan is not covered.

9. Retreatment of Orthodontic cases - The treatment of orthodontic problems that have been treated before are not covered.

Continuing Orthodontic Treatment After Termination

Should a Member be terminated from the Benefit Plan for any reason and at the time of termination be receiving any orthodontic treatment, the Member and not the Plan will be responsible for the payment of balance due for treatment performed after termination. The Member's payment shall be based on the Participating Provider's usual and customary rates, and be pro-rated over the number of months to completion of the treatment and payable on such terms and conditions as are arranged between the Member and the Participating Provider.

VII. COPAYMENTS AND OTHER CHARGES

In addition to the Prepayment Fee, Members must pay a Copayment for those procedures listed with a Copayment in the Schedule of Benefits. The Copayments listed in Schedule of Benefits are applicable to all such services when provided by a Participating Provider. Such services are not covered if provided by any person other than a Participating Provider, except in the case of Emergency Care obtained as required by the terms of this Agreement and Evidence of Coverage.

VIII. SPECIALIST REFERRALS

Generally, specialty care identified as a Covered Service in this Agreement and Evidence of Coverage and Schedule of Benefits is covered only when rendered by a Participating Provider in a Western Dental Center. However, if a Member requires specialty care that is not able to be performed by Participating Providers in the Member's assigned dental office, the Member will be referred to another Participating Provider to obtain specialty care, or to a non-Participating Provider specialist based on the individual Member's medical and dental condition. In such cases where the Member is referred to a non-Participating Provider, the service shall be treated as a Covered Service, and the same Prepayment Fee set forth in the Schedule of Benefits shall apply. See Section X. F., below.

IX. EMERGENCY CARE AND REIMBURSEMENT

If Member requires Emergency Care, he or she is to call the assigned Participating Provider as indicated on the Member's ID membership card. If after contacting the Participating Provider, the Member is advised that the Participating Provider is not available, Member may obtain Emergency Care from any licensed dentist in the area where such dental emergency occurs. Instructions for obtaining Emergency Care are also set forth on the back of the Member's ID membership card.

If Emergency Care is received from a non-Participating Provider, as described above, the Plan will provide a benefit of up to $50 per emergency. The Plan requires an itemized statement of services from the non-Participating Provider to be mailed to the address on the cover page within 180 days for verification of benefit reimbursement. Telephone Member Services at 1-800-992-3366 to receive instructions on the submission of the itemized statement.

X. LIMITATIONS

A. ENDODONTICS – The following Limitation applies to this category of services:

Endodontic services that are beyond the scope of general dentistry practice, including but not limited to root canal treatment of teeth with dilacerated roots, calcified canals, obstructed canals, open apices, or external and internal root resorption are not covered**.**

B. PERIODONTICS - The following Limitation applies to this category of services:

Treatment, evaluation, and planning for periodontal services that are beyond the scope of general dentistry practice is not covered.

C. PROSTHODONTICS, REMOVABLE – The following Limitations apply to this category of services:

1. **Complete and Partial Dentures**

   Over-dentures are not covered unless specifically listed on the attached Schedule of Benefits.

2. **Tooth Additions and Repair to Existing Denture**

   Repair of appliances damaged due to Member abuse is not covered.

D. ORAL SURGERY – The following Limitation applies to this category of services:

1. **Extractions**

   Extraction of third molars that is beyond the scope of general practice dentistry due to unusual surgical complications from factors such as inferior alveolar nerve proximity, high probability of maxillary sinus exposure, and aberrant tooth position are not covered.

2. **Other Surgical Procedures**

   All surgical procedures that are beyond the scope of general dentistry practice are not covered.

E. ORTHODONTICS - The following services are not included in the orthodontic treatment Copayments.

1. Services Required Because of Gross Non-Cooperation – Additional orthodontic services required because Member's cooperation does not meet the minimum level necessary to complete the treatment adequately, or is damaging to the teeth, are not included in the orthodontic treatment Copayments. Failure to attend required appointments, failure to maintain proper oral hygiene, and failure to wear appliances as instructed by the Participating Provider are examples of gross non-cooperation for which the Member would be subject to additional charges that will not be covered by the orthodontic treatment Copayments. (These are examples, not a complete list. Any

gross non-cooperation that adversely affects the outcome of orthodontic care or extends the overall length of treatment beyond the original intended treatment plan may subject the Member to additional charges).

Should treatment extend beyond the original estimated treatment time due to Member's non-compliance, Member will be subject to an office visit Copayment for each additional office visit necessary until orthodontic care is completed. Each such office visit Copayment will equal the result obtained by dividing Member's total original orthodontic treatment Copayment divided by the number of months in the original treatment plan.

2. Lost, Stolen, Damaged or Broken Appliances – Replacement of damaged or lost retainers, brackets, bands, wires or other materials supplied by the orthodontist is not included in the orthodontic treatment Copayments.

3. Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth is not included in the orthodontic treatment Copayments. Examples include, but are not limited to: Bionator, Schwartz Appliance, Herbst Appliance, positioner, headgear, and retainers (without braces). Please see the Schedule of Benefits for a complete list of covered removable orthodontic appliances.

F. SPECIALIST SERVICES –Covered Services, including specialty services, shall be provided by a Participating Provider in a Western Dental Center. If a Member requires specialty services not available from a Participating Provider in the Member's assigned Western Dental Center, the Participating Provider will refer the Member to another Participating Provider who can provide the specialty service. In the event that a Participating Provider in the Member's assigned Western Dental Center or other Participating Providers in other local Western Dental Centers is not available to perform a particular specialty service, the Plan may refer the Member to a non-Participating Provider specialist based on the individual Member's medical and dental condition. In such cases where the Member is referred to a non-Participating Provider, the service shall be treated as a Covered Service, and the same Prepayment Fee set forth in the Schedule of Benefits shall apply. If you require a specialty service, please ask the staff at your assigned Western Dental Center for the nearest Participating Provider that can provide that service. . If you have a question regarding the availability of a specialist service at a particular Western Dental Center, please contact the Plan.

XI. EXCLUSIONS

A. PREVENTIVE SERVICES –

Supplies used for oral hygiene, plaque control, oral psychotherapy instruction, and chemical analysis of saliva are not covered.

B. RESTORATIVE SERVICES –

1. Crowns that are lost, stolen, or damaged when due to Member abuse, misuse or neglect are not covered.
2. Implant supported crowns and abutment supported crowns on a dental implant are

not Covered Services.

C. ENDODONTICS

1. Apexification/Recalcification – Procedures that result in the closure of the tip of the root end (apex) in preparation for a final root canal filling on a tooth with perforated or open apex are not covered.
2. Hemisection – Separation of a multi-rooted tooth into separate sections containing the root and the overlying crown is not covered.
3. Retrograde filling – Sealing and filling the root canal from the root end (apex) is not covered.

All endodontic services that are not specifically identified in the Schedule of Benefits are not covered.

D. PERIODONTICS

1. Osseous Surgery – Surgical procedures involving the reshaping of bone are not covered.
2. Bone Graft – The Benefit Plan does not cover any form of graft used to stimulate bone formation.
3. Soft Tissue graft – Gingival grafts to repair gingival defect or exposed roots are not covered.
4. Tissue Regeneration – Use of biologic material to aid in soft and bony tissue regeneration in repairing periodontal defects is not covered.

All surgical periodontal services that are not specifically identified in the Schedule of Benefits are not covered.

E. PROSTHODONTICS, REMOVABLE

1. Lost, stolen, or damaged appliances due to Member abuse are not covered.
2. Implant supported prostheses are not Covered Services.

F. PROSTHODONTICS, FIXED (Fixed Partial Dentures or Bridges)

1. Lost, stolen, or damaged Fixed Partial Dentures, due to Member abuse are not covered.
2. Distal extension posterior cantilever pontics, which are supported at the front end only are not covered.
3. Implant supported prostheses are not a Covered Service.
4. Correction of Occlusion or "occlusal equilibration" when performed independently of a completed restoration of a prosthesis may be recommended to treat Temporomandibular Joint Disorders (TMJ) or Myofacial pain. In such instances, correction of occlusion is not covered, since this Benefit Plan does not cover treatments of disturbances of the TMJ.

G. ORAL SURGERY

1. Vestibuloplasty – Surgical procedures to increase relative alveolar ridge height are not covered.
2. Treatment of fractures of the upper or lower jawbone is not covered.
3. Excision of benign or displastic (malignant) soft tissue or bony lesions is not covered.
4. Surgical exposure of impacted or unerupted teeth to aid eruption is not covered.

All oral surgical procedures that are not specifically identified in the Benefit Schedule are not covered.

H. ORTHODONTICS (Braces)

The following services are not covered under the Benefit Plan:

1. Extractions for Orthodontic Purposes -Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space is not covered.

2. TMJ/Myofunctional Therapy -Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture are not covered.

3. Surgical Orthodontics - Surgical Orthodontics to reposition the jawbones and teeth is not covered.

4. Treatment of Cleft Palate - Treatment for problems involving holes or voids in the bone that forms the roof of the mouth is not covered.

5. Orthognathic Surgery- Surgery to move the jawbones into alignment is not covered.

6. Treatment of Hormonal Imbalances - The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage is not covered.

7. Class III Orthodontics - Treatment for problems with the growth relationship of the upper and lower jaw resulting in positioning of the lower jaw or teeth in front of the upper jaw or teeth is not covered.

8. Orthodontic Treatment Commenced Prior to Coverage - An orthodontic treatment program that commenced before the Member enrolled in this Benefit Plan is not covered.

9. Retreatment of Orthodontic cases - The treatment of orthodontic problems that have been treated before are not covered.

I. GENERAL EXCLUSIONS

1. Treatment by someone other than a Participating Provider and/or duly qualified technician under the direction of a Participating Provider except for Emergency Care as provided in Section IX., or upon prior authorization by the Plan, is not a Covered Service.
2. Charges for medical treatment, prescriptions, or other non-dental charges incurred

are not covered.

3. Hospitalization costs for any dental procedure, including all hospital services and medications, dental services that are delivered in an inpatient or outpatient hospital setting, and all other associated expenses, including general anesthesia and IV conscious sedation, remain the responsibility of the Member.
4. General anesthesia and IV conscious sedation are not covered, whether provided in a hospital or any other setting.
5. Treatment of malignancies, neoplasms, and cysts is not covered.
6. Treatment of disturbances of the Temporomandibular Joint (TMJ) is not covered.
7. Procedures, restorations, and appliances to correct congenital or developmental malformations are not covered.
8. Dental expenses incurred in connection with any dental procedure started after termination of coverage are not covered.
9. Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage are excluded.
10. Unless specifically identified in the Schedule of Benefits, no dental service is covered, including without limitation, the following: diagnostic services for general dentistry, preventative, restorative, endodontic, periodontic, prosthodontic (fixed or removable), and oral surgery services.
11. Drugs are not covered unless administered by a Participating Provider during the course of treatment for a Covered Service.
12. Further treatment of a Covered Service may be discontinued if the Member continually fails to follow the prescribed course of treatment, and, in such cases, further treatment is not covered.

XII. CHOICE OF PROVIDER

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY RECEIVE BENEFITS AND COVERAGE.

Each Member must receive Covered Services from a Participating Provider. A Member may designate any Western Dental Center as the primary location where they will receive Covered Services. The Member should review the Plan's most current *Provider Directory* to learn what Western Dental Centers are available, and may contact the providers directly at the phone numbers provided to determine their hours of operation. Once a Member has chosen a Western Dental Center, the Member should contact that Western Dental Center to receive Covered Services.

Each Member should designate the Member's primary Western Dental Center at the time they complete the Enrollment Form. If the Member does not designate a Western Dental Center, the Plan will do so. If a Member wants to change their designated Plan office, the Member should contact the Plan.

Services provided by a non-Participating Provider are not covered under the Benefit Plan. Participating Providers are employees of the Plan. The Plan pays each Participating Provider a set amount for each day he or she works. The Plan will not pay a bonus to anyone to deny, reduce, limit, or delay the provision of Covered Services that a Member is entitled to receive.

Upon termination of a Participating Provider, the Plan shall be liable for Covered Services rendered by such Participating Provider, other than for Copayments and excluded services, to a Member who retains eligibility under the Agreement and Evidence of Coverage or by operation of law, and who

was under the care of such Participating Provider at the time of such termination, until the services being rendered to the Member by such Participating Provider are completed, unless the Plan makes reasonable and dentally appropriate provisions for the assumption of such services by a Participating Provider.

The Plan will provide written notice to the Subscriber within a reasonable time of any termination or breach of contract by, or inability to perform of, any contracting provider if the Subscriber may be materially and adversely affected thereby.

SECOND DENTAL OPINIONS

A Member or a Participating Provider may request a second opinion consultation by writing or calling the Plan's Member Services Department at (800) 992-3366. Decisions and notifications regarding requests for second opinion consultations will be rendered within the following time limits: For routine second opinion requests, the decision to approve or deny requests for second opinion consultations will be made within 5 business days of the Plan's receipt of the request. For urgent requests, the second opinion will be authorized or denied within 72 hours of the Plan's receipt of the request. The requesting Participating Provider will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to a requesting Member verbally (when possible) and in writing within 2 business days.

A second opinion consultation may be authorized for surgical procedures, unclear or complex and confusing clinical indications, conflicting test results, the Participating Providers' inability to diagnose the Member's condition, a treatment plan in progress but not improving the Member's condition within an appropriate time period, or the Member's serious concerns about a particular diagnosis or plan of care. A written Explanation of Benefits will be issued to the Member and the Member's Participating Provider, including the name and location of the second opinion provider if the second opinion is approved. Upon approval, the Plan will refer the Member to a Participating Provider for the second opinion. Should there be no available Participating Provider in the appropriate geographical area, the Plan will refer the Member to a non-Participating Provider for a second opinion consultation. A Plan representative will assist the Member in scheduling an appointment or will advise the Member to call and schedule an appointment. The second opinion provider will submit the claim for payment to the Plan. The Member is only responsible for the applicable Copayment as set forth in the Schedule of Benefits. The Plan will pay any cost in excess of the applicable Copayment, and will contact the non-Participating Providers rendering second opinions to advise the provider of The Plan's payment in excess of the Copayment.

The second opinion provider will provide the Member and the Member's Participating Provider with a written narrative report of the results of the Member's consultation. All treatment must be performed by the Member's Participating Provider for the Member to receive benefits under the Benefit Plan. This shall not limit the Member's right to transfer to another Participating Provider in order to receive benefits under the Benefit Plan.

XIII. FACILITIES

Members may obtain a *Provider Directory* by calling the Member Services Department. Western Dental Centers are generally open during normal business hours. Should a Member have a question

regarding the days and/or hours of a Western Dental Center, he/she may write or call the Western Dental Center at the address and telephone number specified in the *Provider Directory*. A copy of the *Provider Directory* is also included in the enrollment package.

A Member may receive Emergency Care after regularly scheduled office hours by calling the local telephone number for the Western Dental Center. The Member will be charged the applicable Copayment as specified in the Schedule of Benefits for "Office Visit - After Regular Scheduled Hours" (ADA procedure code 9440).

XIV. LIABILITY OF MEMBER FOR PAYMENT

By statute, every contract between the Plan and a Participating Provider shall provide that in the event the Plan fails to pay the Participating Provider, the Member shall not be liable to the Participating Provider for any sums owed by the Plan.

In the event the Plan fails to pay non-Participating Providers, the Member may be liable to the non-Participating Provider for cost of services.

XV. RENEWAL PROVISIONS

This Agreement and Evidence of Coverage remains in effect for one year and automatically renews for a new one year term each year upon the expiration of the then current term unless it is terminated or not renewed as provided herein and in the Termination of Benefits Section. Your account will be billed for such automatic renewal, of if you have a credit or debit card on file under your account, such card will continue to be charged for the renewal term(s). In the event that you do not wish your Benefit Plan coverage to automatically renew, you may call the Plan's Member Services Department at (800) 992-3366 any time during your current one year enrollment term but no later than ten (10) days prior to the expiration of the term of enrollment to request to opt out of the automatic renewal process.

XVI. TERMINATION OF BENEFITS

A. Continuing coverage under this Benefit Plan is subject to the terms and conditions of the Agreement and Evidence of Coverage.

B. The Plan may cancel (or, in the case of a Member in orthodontic treatment, not renew) the Agreement and Evidence of Coverage should the Subscriber fail to remit the Prepayment Fee, or any installment thereof, to the Plan. The Plan shall provide notice of termination stating that all unpaid Prepayment Fees must be received by the Plan within a grace period of thirty (30) days beginning on the first day after the last day of paid coverage, and if payment is not received within such thirty (30) day grace period, termination of coverage shall be effective as of the day after the last day of the thirty (30) day grace period. However, subject to Section XVI.C, below, an Agreement and Evidence of Coverage terminated for failure to remit the Prepayment Fee shall be reinstated as though it had never been terminated upon payment of the appropriate Prepayment Fee.

C. The Plan is not required to renew or reinstate the Agreement and Evidence of Coverage if the Plan no longer offers the Benefit Plan set forth in this Agreement and Evidence of Coverage and Schedule of Benefits. Termination shall be effective at midnight of the last day of the enrollment period purchased by any previously paid Prepayment Fee. If the

Agreement and Evidence of Coverage is not renewed or reinstated because the Plan no longer offers the Benefit Plan, Members have the right to enroll in an alternate benefit plan offered by the Plan without penalty.

D. Pursuant to Section 1365 of the Knox-Keene Act, any Member who alleges his/her enrollment has been improperly canceled, rescinded, or not renewed may request review by the Director of the Department of Managed Health Care.

E. The Plan may terminate Member's enrollment in this Benefit Plan if Member knowingly provides false information on his or her Enrollment Form, or fraudulently uses services or facilities of the Plan or providers, or knowingly allows another person to do so. Termination is effective immediately on the date the Plan mails notice of termination.

F. Post termination availability of continuation of orthodontic treatment is described in Section VI, Benefits, of this Agreement and Evidence of Coverage.

G. Except in the case of fraud or deception in the use of services or facilities of the Plan, or knowingly permitting such fraud or deception by another, if a Member's enrollment is terminated, the Plan will within thirty (30) days return the pro rata portion of the Prepayment Fee which corresponds to any unexpired period to which the Prepayment Fee applies, together with amounts due on claims, if any, less any amounts due to the Plan.

XVII. COMPLAINTS AND DISPUTES

Any dispute, complaint or request for information should be directed to the Plan as follows:

WESTERN DENTAL SERVICES, INC.
P.O. Box 14227
Orange, CA 92863
Telephone calls should be made to the Plan at the following number:
Member Services Department: (800) 992-3366

XVIII. GRIEVANCE PROCEDURES

Members are encouraged to contact the Plan at the telephone number listed above regarding any concerns they may have while obtaining services. The Plan maintains a grievance process to address these concerns. Member complaints or grievances can be made in person, at any Participating Provider's office, by obtaining a grievance form from the Plan and submitting it to the Plan, or by submitting the grievance using the Plan's website at www.westerndental.com. There is a representative at the Participating Provider's office or at the Plan's corporate office to aid the Member in filling out the grievance form. Completed grievance forms must be mailed to the Plan at the address listed above. Members will receive a written response within 30 days as to disposition of the grievance. If the Member's grievance involves an imminent and serious threat to his or her health—including, but not limited to, severe pain, potential loss of life, limb, or major bodily functions –the Plan will provide the Member and, as appropriate, the Department with a written statement of the status or disposition of the complaint within three days of receipt of the complaint. Members may appeal, in writing, to the Plan. Member will be informed in writing as to the disposition of the appeal.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against the Plan, you should first telephone the Plan at **1-800-992-3366** and use the 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 the 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 applications forms, and instructions online.

In the event you need any assistance in filing a complaint through the Department's toll-free telephone number, please be advised the Department has a designated staff member who functions as an "ombudsperson" to assist you. A Member may submit a complaint or grievance to the Department for review after the Member has participated in the Plan's grievance process for at least 30 days. If the Member's grievance involves an imminent and serious threat to his or her health--including, but not limited to, severe pain, potential loss of life, limb, or major bodily functions–the Member may submit the grievance to the Department without waiting 30 days. In such a situation, the Plan will immediately inform the Member of his or her right to notify the Department of the complaint.

The Plan will provide written acknowledgement of receipt of a grievance within five (5) calendar days of receipt of the grievance. The acknowledgement will indicate that the grievance has been received, will include the date of receipt of the grievance, and will indicate the name of the plan representative and telephone number and address of the plan representative who may be contacted about the grievance.

XIX. ARBITRATION

Any and all disputes of any kind whatsoever, including, but not limited to, claims for dental malpractice (that is as to whether any dental services rendered under the Plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) between Member (including any heirs, successors, or assigns of Member) and the Plan, except for claims subject to ERISA, shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Member and the Plan are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single neutral arbitrator in accordance with the rules of the American Arbitration Association (the "AAA"). Arbitration, however, shall not be conducted by the AAA, and shall be conducted by another mutually agreed upon arbitration administrator. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the AAA Rules will be utilized.

Arbitration hearings shall be held in the California county in which the Member resides at the time of their initial enrollment, or at such other location as the parties may agree in writing. The

arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of the arbitration administrator and the arbitrator. In cases of extreme hardship, the Plan may assume all or part of the Member's share of the fees and expenses of the arbitration administrator and the arbitrator, provided the Member submits a hardship application to the arbitration administrator. The approval or denial of the hardship application will be determined solely by the arbitration administrator.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The arbitration decision is final and binding on the parties, and the award may only be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

XX. GENERAL PROVISIONS

A. Any provision required to be in this Agreement and Evidence of Coverage by either law or regulation shall automatically bind the Plan, whether or not such provision is actually included in this Agreement and Evidence of Coverage.

B. The Plan is subject to Chapter 2.2 of Division 2 of the Health & Safety Code of the State of California (the "Knox-Keene Act") and to regulations issued thereunder by the Department of Managed Health Care (Title 28 of the California Code of Regulations). Should either the Knox-Keene Act or the regulations be amended, such amendments shall automatically bind the parties, whether or not they are actually included in this Agreement and Evidence of Coverage.

C. Should any Participating Provider be unable to continue in such capacity, whether for breach of contract, inability to perform or termination by the Plan, the Plan shall notify the Member in writing within a reasonable time of its obtaining such knowledge if the Member may be materially and adversely affected. Upon termination of a Participating Provider's contract, the Plan shall be liable for Covered Services rendered by such Participating Provider (other than for Copayments as defined herein and excluded services) to a Member who retains eligibility under this Agreement and Evidence of Coverage or by operation of law, and who was under the care of such Participating Provider at the time of such termination until the services being rendered to the Member by such Participating Provider are completed, unless the Plan makes reasonable and appropriate provisions for the assumption of such services by a Participating Provider.

D. The Plan shall not refuse to enter any contract or shall not cancel or decline to renew or reinstate any contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, or any physical or mental impairment of any contracting party, or person reasonably expected to benefit from any such contract as a Member or otherwise.

The terms of any contract shall not be modified and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reduction, co-payments, co-insurance, deductibles, reservations, or premium, price or charge differentials, or other modifications because of race, color, national origin, ancestry, religion, sex, marital status,

sexual orientation, age, or any physical or mental impairment of any contracting party, prospective contracting party, or person reasonably expected to benefit from any such contract as a Member or otherwise; except that premium, price or charge differentials because of the sex or age of any such individual and based on objective, valid and up-to-date statistical and actuarial data are not prohibited.

E. This Plan does not provide any exception for other coverage where the other coverage is entitlement to: (i) Medi-Cal benefits under Chapter 7 or Chapter 8 of Part 3 of Division 9 of the California Welfare and Institutions Code; or (ii) Medicaid benefits under Subchapter 19 of Chapter 7 of Title 42 of the United States Code. This Plan also does not provide an exemption for enrollment because a Member is entitled to Medi-Cal or Medicaid benefits.

F. The waiver by either of the parties of one or more defaults, if any, under this Agreement and Evidence of Coverage shall not be construed to operate as a waiver of any other or future default, either in the same condition or covenant or any other condition or covenant contained in this Agreement and Evidence of Coverage.

G. Throughout this Agreement and Evidence of Coverage, the singular shall include the plural and the plural shall include the singular; the masculine shall include the feminine and the neuter, and the feminine and the neuter shall include the masculine.

H. If any provision of this Agreement and Evidence of Coverage is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Agreement and Evidence of Coverage, and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevents the accomplishments of the objectives and purposes of this Agreement and Evidence of Coverage.

I. This Agreement and Evidence of Coverage may not be assigned by Subscriber or Members to any third party.

J. The Plan may not increase the Prepayment Fee or decrease benefits under this Agreement and Evidence of Coverage except upon 30-days prior written notice by postage paid mailing at the Subscriber's current address of record with the Plan.

XXI. ORGAN & TISSUE DONATION

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

P.O. Box 14227, Orange, CA 92863
(800) 992-3366 Member Services
www.westerndental.com