COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM DENTAL CARE PLAN ISSUED BY

WESTERN DENTAL SERVICES, INC.

P.O. BOX 14227

ORANGE, CA 92863

(800) 992-3366

Group Plan

Adult Medicare Program

This combined evidence of coverage and disclosure form constitutes only a summary of the dental plan. The dental plan group subscriber agreement must be consulted to determine the exact terms and conditions of coverage.

A specimen copy of the dental group subscriber agreement will be furnished upon request.

WELCOME TO WESTERN DENTAL.

This Evidence of Coverage Booklet, which includes the Combined Evidence of Coverage and Disclosure Form and the accompanying Schedule of Benefits, describes the dental plan being offered by Western Dental Services, Inc., and discloses the terms and conditions of coverage. All applicants have the right to review this Evidence of Coverage Booklet prior to enrollment. Western Dental is called the “Plan” throughout this Evidence of Coverage Booklet.

This Evidence of Coverage Booklet explains a Member’s rights and responsibilities as a Western Dental Member. It also explains the Plan’s responsibilities to the Member. The Evidence of Coverage Booklet contains important information, and should be read completely and carefully. Individuals with special health needs should read carefully those sections that apply to them. Please keep the Evidence of Coverage Booklet in a safe place, available for quick reference. If a Member would like to receive additional information about the benefits of enrollment in Western Dental, please call us at the number above.

This Evidence of Coverage Booklet does not take effect until the Group Subscriber Agreement ("Agreement") between the Member's association, or other entity through which you obtain coverage under the Benefit Plan, ("Group") and Western Dental is approved and executed by the Plan and the Group or association. This Benefit Plan shall be construed under the laws of the State of California; and any action relating to this Benefit Plan shall be instituted and prosecuted in the county in which the Member resides at the time the Agreement is executed or in such other location as the parties may mutually agree in writing.

Please Note: Except for Emergency Dental Care and services prior authorized by the Plan to be provided by Non-Participating Providers, the Covered Services under this Benefit Plan are available only when provided by Participating Providers in accordance with all the terms and conditions of coverage described in this Evidence of Coverage Booklet and the Agreement.

It is the Member's responsibility to determine whether the dentist or specialist dentist chosen is a Participating Provider. It is also the Member's responsibility to determine whether or not a referral made by his or her dentist or Participating Provider is to a Participating Provider. Even though the Member's dentist may be a Participating Provider, do not assume that his or her referral to another dentist/specialist or facility is a determination that such dentist/specialist or facility is also a Participating Provider. If a Member is in doubt about the status of any dentist or facility call the Plan's Member Services Department for verification at 800-992-3366.

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DEFINITIONS

Adult Dentition means the teeth that are present after the cessation of growth that would affect Orthodontic treatment.

Aesthetic Dentistry means any dental procedures, which are performed purely for cosmetic purposes, and where there is no restorative value.

Agreement means the Group Subscriber Agreement between the Member's employer, Group (Group) or association and the Plan.

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 there under.

COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1986, enacted April 7, 1986.

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

Covered Services means the dental services available under the Agreement in which a Member is enrolled.

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

Elective Dentistry means any dental procedures, which are unnecessary to the dental health of the Member, as determined by a Participating Provider.

Eligible Participants means Subscribers of Group or association, who are eligible to participate in the Benefit Plan under the eligibility requirements, set forth by Group or association.

Emergency Dental 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:

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

Exclusions mean any provision of the Benefit Plan whereby coverage for a specified hazard or condition is entirely eliminated.

Group means the employer, group, or employer trust fund or association who has contracted with the Plan to provide the Covered Services described in this Evidence of Coverage Booklet.

Limitation means any provision, other than an Exclusion, which restricts coverage under the Benefit Plan.

Medicare means a federal health insurance program for individuals who are over a certain age and/or disabled.

Member means an Eligible Participant who is enrolled in the Benefit Plan, and for whom Prepayment Fees have been paid to the Plan by the Group.

Non-Participating Provider means a dentist that is not employed by or under contract to provide services for the Plan.

Participating Provider means a dentist that is employed by or under contract with the Plan as a Primary Care Dentist and/or a Specialist.

Plan means Western Dental Services, Inc.

Prepayment Fee means the amount payable each month on a prepayment basis by a Member or the Group (or both) to obtain benefits provided under the Agreement.

Primary Care Dentist or **PCD** means a general or pediatric dentist that coordinates, supports and provides the delivery of dental care and who is a Participating Provider.

Primary Dentition means teeth developed and erupted first in order of time.

Schedule of Benefits means the list of Covered Services, and the authorized Copayment amounts under the Benefit Plan as set forth in this EOC.

Specialist means a dentist who is a Participating Provider who is responsible for the Specific Specialized Dental Care of a Member in one specific field of dentistry such as endodontics, periodontics, oral surgery, or orthodontics where

the Member is referred by a Participating Provider.

Specific Specialized Dental Care means the Covered Services diagnosed and administered to a particular Member by a Specialist, which a Member receives as a result of a referral to the Specialist or other Participating Provider.

Subscriber means the individual enrolled in the Benefit Plan for whom the appropriate Prepayment Fee has been received by the Plan, and whose status, is the basis for enrollment eligibility.

Transitional Dentition means the final phase of the transition from primary to adult teeth, in which the deciduous teeth are in the process of shedding and the permanent successors are emerging.

Urgent Care means health care for a condition which requires prompt attention.

ACCESS TO SERVICES

Facilities

Members may obtain a list of the Plan's Participating Providers by calling the Member Services Department at (800) 992-3366. Participating Providers are open during normal business hours as specified in the Participating Provider listing. Should a Member have a question regarding the days and/or hours of the Participating Provider's facility, he/she may reference the Provider listing or may write or call either the Participating Provider at the address and telephone number specified on the Provider list or the Plan at the address and telephone number listed in this Evidence of Coverage Booklet. A copy of the Provider Listing is also included in the Enrollment Package.

A Member may receive Emergency Dental Services after regularly scheduled office hours by calling the local telephone number for the Participating Provider's facility. 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 9940)."

Choice of Dentists

PLEASE READ THE FOLLOWING INFORMATION TO KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS A MEMBER MAY RECEIVE BENEFITS AND COVERAGE.

Each Member must receive Covered Services from a Participating Provider. When a Member needs to visit his or her dentist, he or she must first see the Primary Care Dentist chosen at the time of enrollment. A Member may designate any Primary Care Dentist who is available. The Member should review the Plan's most current *Provider Directory* for the Plan that covers the Member to learn who may be available. Once a Member has designated a Primary Care Dentist, the Member should contact the Primary Care Dentist to receive Covered Services. The Member's Primary Care Dentist's name and telephone number are on the Member's Plan ID card.

Each Member should designate the Member's Primary Care Dentist on his or her enrollment form. If the Member does not designate a Primary Care Dentist, the Plan will do so. If a Member wants to change Primary Care Dentists, the Member should contact the Plan. If the request for transfer is received by the Plan by the 15th day of the month, this transfer will become effective on the first day of the following month.

If a Member needs help choosing a Primary Care Dentist or want to change his or her Primary Care Dentist, please contact the Member Services Department at (800) 992-3366.

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 Plan.

However, services provided by a Non-Participating Provider are not covered under the Benefit Plan, and the Member may be liable to Non-Participating Providers for cost of those services, except for Emergency Dental Care provided by Non-Participating Providers which the Plan will pay for up to a one hundred dollar ($100) maximum allowable benefit (see " Emergency and Urgent Care" below).

PROVIDER REIMBURSEMENT

Some Participating Providers are employees of the Plan. The Plan pays each Participating Provider who is an employee 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.

Some Participating Providers are independent dentists under contract with the Plan. The Plan pays those Participating Providers based on the agreements reached with them. The amount the Participating Provider will receive (for example, capitation payments) might not depend on the nature or amount of services provided to a Member. On the other hand, the amount the Participating Provider will receive (for example, fee-for-service payments) might depend entirely on the nature and amount of services provided.

Timely Access to Care

Urgent Dental Care

If you require Urgent Dental Care and make an appointment, you shall be seen by a primary dentist for emergency care within 24 hours of the request of the appointment. In addition, you are not required to obtain prior authorization by us to received Urgent Dental Care. Upon a showing that you will not suffer any detrimental impact to your health, your doctor may extend the wait time for an Urgent Dental Care appointment to 72 hours of the request for the appointment. If a doctor is unable to see you within the time periods noted above, please contact a Western Dental representative immediately at 1-800-992-3366. The Western Dental representative shall ensure that you are treated within the required time periods.

Non-urgent Dental Care

If you care is for non-Urgent Dental Care services, your doctor is obligated to see you within ten (10) business days of the request for an appointment. Upon showing that you will not suffer any detrimental impact to your health, your doctor may extend the waiting time for a non-urgent dental care appointment to thirty-six (36) business days of request for an appointment. Unless requested by you to accommodate your schedule, in no case shall a doctor schedule an appointment that is not within the required time periods of the request for an appointment. If a doctor is unable to see you within the time periods noted above, please contact a Western Dental representative immediately at 1-800-992-3366. The Western Dental representative shall ensure that you are treated within the required time periods.

Preventative Dental Care

If your care is for preventative dental care services, your doctor is obligated to see you within ten (10) business days of the request for an appointment. Upon showing that you will not suffer any detrimental impact to your health, your doctor may extend the waiting time for a preventative dental care appointment to forty (40) business days of request for an appointment. Unless requested by you to accommodate your schedule, in no case shall a doctor schedule an appointment that is not within the required time

periods of the request for an appointment. If a doctor is unable to see you within the time periods noted above, please contact a Western Dental representative immediately at 1-800-992-3366. The Western Dental representative shall ensure that you are treated within the required time periods.

Interpretive Services

Whether you require routine or Urgent Dental Care and you need any assistance communicating with your doctor, Western Dental shall make available at no cost to you an interpreter. Prior to your appointment, please contact a Western Dental representative at 1-800-992-3366. The Western Dental representative will make all necessary arrangements to ensure that an is present while you are being treated by your doctor.

EMERGENCY DENTAL CARE AND URGENT CARE

The Plan provides coverage for Emergency Dental Care if the services are required to alleviate severe pain or bleeding or if the Member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death. Emergency Dental Care is available for all Western Dental patients 24 hours a day, 7 days a week.

The Plan provides coverage for Urgent Care if the services are required to prevent the serious deterioration of dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed, or if the Member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death.

In the event that Member requires Emergency Dental Care or Urgent Care during regular Provider office hours, the Member should contact his or her Primary Care Dentist to schedule an immediate appointment. After business hours, the Member should contact his or her Primary Care Dentist, and the on-call dentist will return the call for instructions on how to proceed.

If after contacting his or her Primary Care Dentist, the Member is advised that the Primary Care Dentist is not available, the Member may obtain Emergency Dental Care or Urgent Care from any Participating Provider or any licensed dentist in the area where such dental emergency occurs.

If a Member is out of the area and requires Emergency Dental Care or Urgent Care, Member may contact Western Dental for referral to another contracted

dentist that can treat the condition, or Member may proceed to find a dentist who can treat the condition.

Members may contact the Plan for assistance with obtaining an emergency appointment from a Participating Provider. Treatment by Participating Providers will be provided at the applicable Copayment listed in the Schedule of Benefits. However, there is a one hundred dollar ($100) maximum allowable benefit for Emergency Dental Care and for Urgent Care provided by a Non-Participating Provider. The Plan requires an itemized statement of services from the Non-Participating Provider or the Member within one-hundred eighty (180) days from the date of service for verification of benefit reimbursement.

The Member must include the itemized statement of services, the Member's name, address, Member ID number**,** dates of service, treating provider's name, address**,** and telephone number, and a statement of the problem, and mail it to:

Western Dental Services, Inc.
Attn: Specialty Referrals/Claims Department
P.O. Box 14227
Orange, California 92863

The Member should retain a copy of the information, and the Plan will either send the Member a check or explain any denial within thirty (30) business days of the Plan's receipt of the Member's claim.

Members are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when they have an emergency dental condition that requires an emergency response.

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 who is under contract with the Plan. 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 provider rendering the second opinion to advise the of Western Dental'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 Covered Services under the Benefit Plan. This shall not limit the Member's right to transfer to another Participating Provider in order to receive Covered Services under the Benefit Plan.

CONTINUITY OF CARE

Current Members:

Current Members may be eligible to temporarily continue receiving Covered Services from a Non-Participating Provider for treatment of certain specified dental conditions, where the Non-Participating Provider was formerly contracted with the Plan, and where the services were being provided to the Member at the time the provider's contract with the Plan was terminated (i.e. a "terminated provider"). Members can call the Plan's Member Services Department at (800) 992-3366 regarding eligibility for this benefit. A Member may request a copy of the Plan's continuity of care policy from the Plan's Member Services Department. A Member must make a specific request to continue under the care of a terminated provider. The Plan is not required to continue a Member's care with a terminated provider if the Member is not eligible under the Plan's

continuity of care policy or if the Plan cannot reach agreement with the terminated provider on the terms regarding the Member's care in accordance with California law.

New Members:

New Members may be eligible to temporarily continue receiving Covered Services from a Non-Participating Provider for treatment of certain specified conditions if the services were being provided by a Non-Participating Provider at the time the Member's coverage under the Benefit Plan became effective. Members can call the Plan's Member Services Department at (800) 992-3366 regarding eligibility for this benefit. A Member may request a copy of the Plan's Continuity of Care Policy from the Plan's Member Services Department. A Member must make a specific request to continue under the care of his or her Non-Participating Provider within 30 days from the Member's enrollment date with the Plan. The Plan is not required to continue a Member's care with a Non-Participating Provider if the Member not eligible under the Plan's Continuity of Care Policy or if the Plan cannot reach an agreement with a Non-Participating Provider on the terms regarding the Member's care in accordance with California law.

REFERRALS

The Plan provides referral to the following specialties for covered services: Periodontics, Endodontics, Oral Surgery, and Pedodontics. Referable procedures that are not available in the contracted dental office are covered at 75 percent of the contracted specialist's usual fee or if available at a Western Dental Center specialist at 50 percent of the contracted Western Dental Center specialists usual fees.

The Member must first visit his or her Primary Care Dentist for evaluation of Member's case. If the Primary Care Dentist determines the Member requires a referral to a Specialist, the Member's Primary Care Dentist will initiate a referral to a Specialist on behalf of the Member. The Primary Care Dentist will submit the referral request to the Specialty Referral Department of the Plan, using the Specialist Referral Form. The process used by the Plan to review requests for Specialty Referrals and other benefits are available from the Member Services Department.

PLEASE NOTE: If the request for Specialist services is not made in compliance

with the foregoing, the Member will be responsible for the Specialist's full usual and customary fees for any such services rendered.

AUTHORIZATION, MODIFICATION OR DENIAL OF SERVICES

Members and Participating Providers are notified of authorizations and denials of Specialist Referral Requests as follows: For routine referrals, the decision to approve, modify, or deny requests by a Member's Primary Care Dentist for specialty referrals will be made in a timely fashion. The Plan will take into consideration the Member's condition. Referrals will be processed within five (5) business days of the Plan's receipt of the information that is reasonably necessary and requested by the Plan to make the determination.

When the Member's condition is such that the Member faces an imminent and serious threat to his or her dental health, the Plan shall expedite the review process. The Plan shall make a decision within 72 hours of receipt of all necessary information.

The requesting Participating Provider will be notified by telephone or facsimile within 24 hours of the Plan's decision. The decision will be communicated to the requesting Participating Provider and the Member verbally (when possible) and in writing within 2 business days.

If the referral is approved, the Plan shall specify in the notice the specific dental care service approved. Upon receipt of notification of approval, the Member may contact the Specialist to schedule an appointment. The Specialist will provide Specific Specialized Dental Care for the Copayment listed in the Schedule of Benefits. The Specialist will submit the claim for payment to the Plan and the Member shall be responsible for payment of the Copayment, as applicable.

If the referral is denied or modified, the Plan shall specify the reasons for the decision, The Plan shall include a clear and concise description of the utilization review of criteria or guideline used, and the clinical reasons for the decision regarding medical necessity. The Plan, and shall include the name and direct telephone number or extension of the dental professional who made the decision at the Plan. Members are also notified in the denial notices as to how they may file a grievance to appeal denials with the Plan

In cases where the request is retroactive (i.e., where the Member has already

obtained the services from the Specialist), the Participating Provider and Member shall receive written notification of the Plan's decision within thirty (30) calendar days from the Plan's receipt of the information that is reasonably necessary to make the determination.

In the case of concurrent review (i.e., where the care is already underway), care shall not be discontinued until the Member's treating Participating Provider has been notified of the Plan's decision and a care plan has been agreed upon by the treating Participating Provider that is appropriate for the dental needs of that Member.

FEES AND CHARGES

Premiums

The Plan shall provide or arrange for the provision of the Covered Services specified in the Agreement. The Group shall pay the Prepayment Fee set out on the last page of the Schedule of Benefits.

The Prepayment Fee must be paid in full by Group or association at the Plan's address set out on the first page of this Evidence of Coverage Booklet by the 25th day of the month to which the Prepayment Fee applies. (For example, Prepayment Fees for the month of July are due no later than July _.) Member should consult Group or association for specific information regarding any sums to be paid by Subscriber to the Group or association.

Copayments

In addition to the monthly Prepayment Fees, if any, a Member will pay a Copayment for those procedures or services listed in the attached Schedule of Benefits. All Copayments are paid by the Member directly to the Participating Provider. All Covered Services are listed in the Schedule of Benefits regardless of whether a Copayment applies. Those Covered Services that do not require a Copayment are designated in the Schedule of Benefits as "No Copayment."

During the term of the contract, the Plan may not change the Prepayment Fees and the Copayment amounts paid by the Members in any manner during a contract term without a prior written agreement between the Group or association and Plan.

LIABILITY FOR PAYMENT

Refer to section ACCESS TO SERVICES - Liability of Member for Payment

ELIGIBILITY AND ENROLLMENT

Eligibility

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

Effective Date of Coverage

Coverage shall commence on the date specified in the Agreement for all Members enrolled as of the commencement date of the Agreement. A waiting period will apply if specified in the Agreement. Coverage shall commence for all new Members on the first day of the month following the Plan's receipt of Prepayment Fees for such new Members.

Identification Card

The Plan issues each Member an identification card to be presented by the Member at the time that services are to be rendered by the Participating Provider. If an ID Card is lost, please call the Member Services Department at (800) 992-3366 to request a new one. If a Member contacts us to change his or her assigned Primary Care Dentist, a new ID card will be mailed to the Member with the new Primary Care Dentist's name, address and telephone number.

COVERED SERVICES

Benefit and Coverage Matrix

This matrix is intended to be used to help you compare coverage benefits and is a summary only. Please refer to this Evidence of Coverage and your Schedule of Copayments and Covered Benefits for more information about services covered under your plan.

Deductibles	**Maximums**
None	None
Professional Services	
Copayments vary by procedure and can be found on your Schedule of Covered Services and Copayments. Categories of services include:	
Diagnostic Services - $0 Preventive Services - $0- $65 Restorative - $20-$590	Periodontic Services - $55-$500 Prosthodontic Services - $35 - $500 Orthodontic Services – Not a covered benefit
Outpatient Services	**Hospitalization Service**
No additional charge	Not covered
Emergency Dental Coverage	
Please refer to the Emergency Care section of this Evidence of Coverage	
Ambulance Service	**Prescription Drug Coverage**
Not covered	Not covered
Durable Medical Equipment	**Mental Health Services**
Not covered	Not covered
Chemical Dependency	**Home Health Services**
Not covered	Not covered

The Benefit Plan provides coverage for services when necessary for your dental health 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.

A list of covered dental benefits follows:

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. Refer to the "Diagnostic" category on the Schedule of Benefits to determine what specific procedures are Covered Services and their Copayment amounts.

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. Detailed and Extensive Oral Evaluation – A detailed and extensive problem-focused evaluation based on the findings of a comprehensive oral evaluation, and development of a treatment plan for the specific problem evaluated. The condition requiring this type of evaluation should be described and documented.

4. 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
   - Detailed and Extensive Oral Evaluation

5. 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.

6. Pulp Vitality Test – Assessment of vitality of the pulp tissue which occupies the pulp cavity of the tooth.

B. **Preventative** – Those procedures that aid in the prevention of dental and oral disease. Refer to the "Preventive" category of the Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

Preventive Services may include the following:

1. Prophylaxis (Adult) – 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.

C. **Restorative Services** – Those procedures used to repair and restore the natural teeth to healthy condition. Refer to the "Restorative Services" category of the Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

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. Metal upgrade charges apply to a maximum of $125. Please refer to you schedule of benefits to confirm which procedures will have metal upgrade charge.

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.

D. Endodontics – Those procedures that involve treatment of the pulp, root canal and roots. Refer to the "Endodontics" category of the Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts. When referred to a contracted specialists for specialized services the member will be charged 75 percent of the contracted specialists usual fees or if available at a Western Dental Center specialist the member will charged 50 percent of the specialists usual fee.

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.

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). Refer to the "Periodontics" category of the Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts. When referred to a contracted specialists for specialized services the member will be charged 75 percent of the contracted specialists usual fees or if available at a Western Dental Center specialist the member will charged 50 percent f the specialists usual fee.

1. Periodontal Services (Surgical). The following Periodontal Services (Surgical) are Covered Services
   a) Gingivectomy – Removal of part of the gingival margin resulting in exposure of more tooth structure.

   c) Osseous Surgery – Surgical procedure involving the reshaping of the bone to achieve a more healthy and physiologic status.

2. Periodontal Services (Non-surgical)

   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.

F. **Prosthodontics, Removable**– Replacement of lost teeth by a removable prosthesis and the maintenance of those appliances. Refer to the "Prosthodontics (Removable)" category of the Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

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.

   Replacement of an existing appliance will be covered if the appliance is over five years old. The five year limitation does

not apply to services rendered while the Member was not covered, to clinically defective dentistry, or when replacement is necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

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.

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.

G. Prosthodontics, fixed (Fixed Partial Dentures or Bridges) – Replacement of lost teeth by fixed prosthesis is a Covered Service. Refer to the "Prosthodontics, Fixed" category of the Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

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.

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.

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. Refer to the "Oral and Maxillofacial Surgery" category of the Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts. When referred to a contracted specialists for specialized services the member will be charged 75 percent of the contracted specialists usual fees or if available at a Western Dental Center specialist the member will charged 50 percent f the specialists usual fee.

1. Extractions – Removal of teeth or parts of teeth.
2. Other Surgical Procedures.

LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS

Limitations

The following Limitations apply to Covered Services set out in the Benefits Section of this Evidence of Coverage Booklet. Where the description of a Limitation refers to the Schedule of Benefits for more information or detail, refer to the corresponding category heading in the Schedule of Benefits.

A. **Diagnostic –** The following limitations apply to this category of services:

Full Mouth X-Ray/Bite Wing X-Ray –

1. Coverage for full-mouth X-ray is limited to once in a two (2) year period.
2. Coverage for bite wing X-rays is limited to no more than one series of four in any six-month period, unless the Participating Provider determines additional X-rays are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

B. **Preventive –** The following Limitations apply to this category of services:

Prophylaxis

The Plan provides coverage for these “teeth cleanings” only twice in twelve months. If applicable, the Copayment for each cleaning is specified in the Schedule of Benefits. An additional prophylactic cleaning will be covered if the treating Participating Provider deems it necessary for the dental health of the Member, consistent with professionally recognized standards of dental practice. Some examples of situations where additional prophylaxes may be necessary for the dental health of the Member are:

1. Pre-radiation therapy as ordered by an oncologist;
2. Gingival hyperplasia due to the use of Dilantin for the treatment of epilepsy;
3. Inflammation due to syphilis or tuberculosis;
4. Chronic menopausal gingivostomatitis; and
5. Leukemia or HIV induced gingivitis.

Fluoride Treatments

a) Topical Fluoride is a benefit for Members over the age of 18 years, unless the treating Participating Provider determines topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

b) Topical Fluoride Treatments are limited to one (1) treatment in a six (6) consecutive month period, unless the treating

Participating Provider determines additional topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

C. Restorative Services – The following Limitations apply to this category of services:

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.

Crowns

1. Crowns will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care (Example: buccal or lingual walls are either fractured or decayed to the extent that they do not hold a filling).

2. Replacement of an existing crown will be covered if the crown is over five years old or if the existing crown cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental practice. The five-year limitation does not apply to clinically defective dentistry or to services rendered while the Member was not covered under this Benefit Plan.

3. Precious metal crowns – use of precious metal in fabrication of a crown is considered elective unless specifically listed as one of the Covered Services of the Member's Plan. (See attached Schedule of Benefits for detailed information). If the Member elects to receive a precious metal crown that is not a Covered Service, the Member must pay the Participating Provider's charges that exceed the Copayment for a full cast metal crown. Metal upgrade charges apply to a maximum of $125. Please refer to you schedule of benefits to confirm which procedures will have metal upgrade charge.

Other Restorative Services

Dowel Posts or Pins

These items are not covered except where insufficient coronal structure remains to retain the crown restoration.

D. **Periodontics –** The following Limitations apply to this category of services:

Scaling and Root Planing

Periodontal scaling and root planning – one (1) per quadrant per twenty-four (12) consecutive months.

Periodontal maintenance following active periodontal therapy-two (2) per twelve (12) consecutive months in combination with routine prophylaxis

Surgical periodontal procedures- one (1) per thirty-six (36) consecutive month period per area of the mouth.

When referred to a contracted specialists for specialized services the member will be charged 75 percent of the contracted specialists usual fees or if available at a Western Dental Center specialist the member will charged 50 percent f the specialists usual fee

E. **Prosthodontics, Removable –** The following Limitations apply to this category of services:

Complete and Partial Dentures

Replacement of an existing appliance will be covered if the appliance is over five years old. Replacement of appliances that are less than five years old is covered only if the appliance was originally provided while the Member was not covered under any Western Dental Benefit Plan, if replacement is required as a result of clinically defective dentistry, or when replacement is necessary for the dental health of the Member consistent with professionally recognized standards of dental practice and preauthorized by the Plan.

Tooth Additions and Repair to Existing Denture

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

Denture Reline and Rebase

Relines of full or partial dentures are limited to twice per calendar year, unless the treating Participating Provider determines that additional relines are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

F. Prosthodontics, Fixed (Fixed Partial Dentures or Bridges) – The following Limitations apply to this category of services:

Fixed Partial Dentures, Pontics, and Crowns

1. Replacement of an existing appliance will be covered if the appliance is over five years old. The five year limitation does not apply to services rendered while the Member was not covered, or to replacement required as a result of clinically defective dentistry.

2. Precious metal Fixed Partial Dentures are not covered unless specifically listed as a Covered Service of the Member's Benefit Plan in the Schedule of Benefits or the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice. If the Member elects to receive a precious metal Fixed Partial Denture when it is not a Covered Service, the Member must pay the Participating Provider's charges that exceed the Copayment for a non-precious metal Fixed Partial denture.

3. Stress Breaker (non-rigid connector between the abutment and the pontic) is not covered unless specifically listed as a Covered Service of the Member's Benefit Plan in the Schedule of Benefits or the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

Fixed Partial Dentures Services

Posts are not covered except where insufficient coronal structure remains to retain the crown restoration.

G. Oral Surgery – The following Limitations apply to this category of services:

1. Extractions for orthodontic purposes are not covered if the tooth is not diseased.
2. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one of more impacted teeth when the extractions qualifies as a referable

procedure, as administered by a licensed oral surgeon.

When referred to a contracted specialists for specialized services the member will be charged 75 percent of the contracted specialists usual fees or if available at a Western Dental Center specialist the member will charged 50 percent f the specialists usual fee

I. **Specialist Referrals –** Prior authorization from the Plan is required for coverage of dental services provided by a Specialist. Please refer to the "REFERRALS" Section of this Evidence of Coverage Booklet.

When referred to a contracted specialists for specialized services the member will be charged 75 percent of the contracted specialists usual fees or if available at a Western Dental Center specialist the member will charged 50 percent f the specialists usual fee

Exclusions

The following dental procedures and services are not covered by the Benefit Plan. No dental service is covered unless specifically identified in the Schedule of Benefits. Where the description of an Exclusion refers to the Schedule of Benefits for more information or detail, refer to the corresponding category heading in the Schedule of Benefits.

A. Preventive

Supplies used for oral hygiene, plaque control, oral psychotherapy instruction, and chemical analysis of saliva.

B. Restorative Services

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

C. Periodontics

The following Periodontal Services are not covered unless specifically identified in the Schedule of Benefits:

1. Crown Lengthening – Surgical procedure involving the removal of gingiva and supporting bone to expose more tooth structure in preparation for a crown procedure is not covered unless specifically listed as a Covered Service of the Member's Benefit Plan. (See attached Schedule of Benefits for detailed information.)

2. Bone Grafts – Use of various forms of graft to stimulate bone formation is not covered unless specifically listed as a Covered Service of the Member's Benefit Plan. (See attached Schedule of Benefits for detailed information.)

3. Soft Tissue Graft – Use of gingiva as a graft to repair a gingival defect or an exposed root is not covered unless specifically listed as a Covered Service of the Member's Benefit Plan. (See attached Schedule of Benefits for detailed information.)

4. Full Mouth Debridement – Removal of plaque and calculus that obstruct the ability to perform an evaluation. This procedure is not covered unless specifically listed as a Covered Service of the Member's Benefit Plan. (See attached Schedule of Benefits for detailed information.)

D. Prosthodontics, Removable

1. Lost, stolen, or damaged appliances due to Member abuse are not covered.

2. Removable Prosthetic Services and supplies that are cosmetic in nature.

3. Implant supported prostheses are not a Covered Service.

4. Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances are not covered.

5. Overdentures (dentures that overlie, and are supported by, a retained tooth root or a dental implant) are not covered.

E. Prosthodontics, Fixed (Fixed Partial Dentures or Bridges)

1. Lost, stolen, or damaged Fixed Partial Dentures, due to Member abuse is 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.

5. Fixed Partial Dentures are not covered if the Member is missing teeth on opposite sides of the same arch, because a Removable Partial Denture is considered an adequate replacement. If the Member elects to receive a Fixed Partial Denture, the Member must pay the Participating Provider's charges that exceed the Copayment for a Removable Partial Denture as set forth in the Schedule of Benefits. This exclusion does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

7. Fixed Partial Dentures are not covered unless a Removable Partial Denture cannot satisfactorily restore the case according to professionally recognized standards of dental practice. This limitation does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

8. Fixed Partial Dentures are not covered when abutment teeth are healthy and would be crowned only for the purpose of supporting a pontic. If Fixed Partial Dentures are used under these circumstances, it is considered elective and is not a Covered Service, and the Member must pay the Participating Provider's charges that exceed the Copayment for a

Removable Partial denture as specified in the Schedule of Benefits. This limitation does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

F. **Oral Surgery**: any procedure that is not specifically listed as a Covered Services in the Schedule of Benefits.

H. **General Exclusions**

The following general exclusions are applicable to all services:

1. Treatment by someone other than a Participating Provider and/or duly qualified technician under the direction of a Participating Provider except for Emergency treatment as provided in the "EMERGENCY AND URGENT CARE" Section of this Evidence of Coverage, or upon prior authorization by the Plan.

2. Charges for medical treatment, prescriptions, or other non-dental charges incurred.

3. Hospitalization costs for any dental procedure, including all hospital services and medications, will be borne by the

Member. When deemed medically necessary by the Member's physician and preauthorized by the Plan, otherwise covered dental services that are delivered in an inpatient or outpatient hospital setting are Covered Services under the Benefit Plan. See attached Schedule of Benefits for applicable Copayments. All other associated expenses, including general anesthesia and IV conscious sedation, except as specifically listed in the limitation section of this document, remain the responsibility of the Member.

4. Treatment of malignancies, neoplasms, and cysts.

5. Treatment of disturbances of the Temporomandibular Joint (T.M.J.).

6. Procedures, restorations, and appliances to correct congenital or developmental malformations.

7. Services and supplies which are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice are not covered.

8. Dental expenses incurred in connection with any dental procedure started after termination of coverage.

9. Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage are excluded.

10. Appliances to correct and control harmful habits are not covered (e.g. tongue thrust and thumb sucking), unless specified in the accompanying Schedule of Benefits (See attached Schedule of Benefits for detailed information.). This exclusion is not intended to eliminate coverage for dental services based on the cause of the underlying condition being treated.

TERMINATION, RESCISSION AND CANCELLATION OF COVERAGE

Termination of Benefits

A. Upon termination of a Subscriber's employment or membership with the Group or association, Member, shall continue to be eligible to receive services until the last day of the month in which the Subscriber's termination occurred. (See "COBRA" section for continuation under COBRA).

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

C. Pursuant to Section 1365(b) of the Knox-Keene Act, any Member who alleges his/her enrollment has been cancelled or not renewed because of the Member's health status or requirements for health care services may request review by the director of the Department of Managed Health Care.

D. The Plan may terminate Member's enrollment in this Benefit Plan under the following circumstances:

If the 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 30 days after Notice of Cancellation, Rescission, or nonrenewal is sent to the Member. A notice of End of Coverage shall be sent to the Member no later than 5 (five) calendar days after the date of coverage ended.
If coverage is terminated for the reasons stated in this subsection D, Member forfeits all rights to COBRA Continuation Coverage or to enroll in the plan's individual conversion or other benefit plans in the future. The Plan does not provide for Member reinstatement following termination of individual membership.

E. Participating Providers shall complete all procedures that were commenced prior to the date of the Member's termination, except for orthodontic treatment. Post termination arrangements for continuation of orthodontic treatment are described in the

"BENEFITS - Orthodontics" section.

F. The Agreement between the Plan and Group shall not be canceled or not renewed except for specific reasons permitted by the Knox-Keene Act, including but not limited to the following circumstances:

- Failure to Pay Prepayment Fees. Group or association fails to pay any Prepayment Fee when due under the Agreement. The Plan will provide the Group with 30 days notice before cancellation of the Agreement for non-payment. Termination is effective as of the first day after the 30–day notice period.

- Fraud or Deception in Use of Services. Group or association engages in fraud or deception in the use of the services or facilities of the Plan, or knowingly permitted such fraud or deception by someone else. The Plan will provide the Group with a notice of termination. Termination will be effective at midnight on the date specified in the notice of termination, not less than 30 days after such notice.

- Fraud or Deception with Respect to Coverage. Group or association engages in fraud or misrepresentation with respect to the Agreement or the coverage of any person. The Plan will provide the Group with a notice of termination. Termination will be effective on the date specified in the notice of termination, not less than 30 days after such notice.

- Failure to Comply with Contribution Requirements. Group or association fails to comply with Group contribution level requirements set forth in the Agreement. The Plan will provide the Group with a notice of termination. Termination will be effective on the date specified in the notice of termination, not less than 30 days after such notice.

G. Enrollees subject to cancellations and nonrenewals for nonpayment of premiums will be sent a Notice of Start of Grace Period. These enrollees are entitled to a grace period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated, prior to cancellation, as follows: The grace period may not begin sooner than the day after the last date of paid coverage.

- A plan shall provide coverage pursuant to the terms of the contract during the entire grace period.

- Upon determining that an enrollee, subscriber, or group contract holder has failed to make a premium payment by the due date, the plan shall send a Notice of Start of Grace Period to the enrollee, subscriber, or group contract holder, notifying the recipient that a payment delinquency has triggered a grace period starting from the day the Notice of Start of Grace Period is dated.

- The plan shall continue the enrollee, subscriber, and/or group contract holder's coverage uninterrupted pursuant to the plan contract upon payment of all outstanding premium amounts at any time before the expiration of the grace period.

- The enrollee, subscriber, or group contract holder is financially responsible for any and all premiums and any copayments, coinsurance, or deductible amounts obligated under the plan contract, including those incurred for services received during the grace period.

- The plan shall send a Notice of Start of Grace Period to each subscriber in a group contract unless:
  - The plan contract requires the group contract holder to promptly send any such notice to each subscriber; and
  - The plan sends the notice to the group contract holder designated in the plan contract.

- In the event the plan, after compliance with all timing and notice requirements of this section, fails to receive all outstanding premium amounts from the enrollee, subscriber, or group contract holder on or before the last day of the grace period, as specified in the Notice of Start of Grace Period, coverage may be cancelled prospectively only after the expiration of the entire grace period.

H. Termination of coverage is effective for all Members, including those who are hospitalized or undergoing treatment for an ongoing condition. According to the terms of the Agreement, the Group is responsible for notifying the Member if and when the Agreement is terminated for any reason, including the non-payment of Prepayment Fees, and for providing the Member with a copy of the notice of termination provided to the Group by the Plan.

Note: If the Agreement with the Member's Group is terminated by the Plan, reinstatement of the Group's Agreement with the Plan is subject to all terms and conditions of that Agreement.

RENEWAL AND REINSTATEMENT OF COVERAGE

Renewal Provisions

The Plan has contracted to provide Covered Services for a period as specified in the Agreement. Thereafter, the Agreement may be renewed, with or without amendments, as specified in the Agreement. The Group or association may terminate the Agreement by giving the other party at least sixty (60) days written notice prior to the termination date of the Agreement. Failure to give such notice shall automatically renew the Agreement for a subsequent renewal term as specified in the Agreement. The Plan may change the Prepayment Fee and the Covered Services at the beginning of any renewal term of the Agreement by giving notice setting out the changes at least sixty (60) days prior to the start of the renewal term for which the changes are to be effective.

The Plan may not change the Prepayment Fee, the Copayment amounts paid by the Members, and the Covered Services in any manner during the contract term without a prior written agreement between the Group or association and Plan.

CONTINUATION OF BENEFITS

Individual Continuation of Benefits

1. Loss of Group Eligibility-The Member who becomes ineligible for group coverage may apply within 30 days of notice of ineligibility to continue Benefit Plan coverage. The terms and conditions under the Agreement in which such Member was enrolled shall continue in effect with the following exceptions: Notices and distribution of materials as required will be delivered directly to the Member; Member shall pay the applicable monthly premium in effect at the time the application to continue coverage is approved by the Plan. Such extension of coverage shall apply to the Dependent(s) of the converting Members upon the same terms and conditions as applied to the converting Member. Such application may be accepted or rejected at the option of the Plan; no automatic right of individual continuation of benefits exits.
2. Loss of Eligibility Due to Termination of Agreement - Plan reserves the right to offer conversion privileges to the Subscriber who becomes ineligible due to the termination of the Agreement. Should such conversion be offered to the Subscriber, application must be made within 30 days of notice of ineligibility to continue Benefit Plan coverage. The terms and conditions under the Agreement in which such Subscriber was enrolled shall continue

in effect with the following exceptions: Notices and distribution of materials as required will be delivered directly to the Subscriber; Subscriber shall pay the applicable monthly premium in effect at the time the application to continue coverage is approved by the Plan. Such extension of coverage shall apply to the Dependent(s) of the converting Subscriber upon the same terms and conditions as applied to the converting Subscriber.

Cal-COBRA Continuation Coverage After COBRA

In the event a Member's Federal COBRA coverage began on or after January 1, 2003 and he or she has exhausted his or her Federal COBRA benefits, the Member may be eligible to continue benefits under "Cal-COBRA," as described below, at 110 % of the premium charged for similarly situated eligible employees currently working at the Member's former employment. A notice will be provided to the Member at the time the Member's COBRA benefits will exhaust, allowing up to 18 more months, but not to exceed 36 months from the date the Federal COBRA benefits began.

The California Continuation of Benefits Replacement Act ("Cal-COBRA") requires that employer groups with fewer than twenty (20) eligible employees offer eligible employees and their families the opportunity for a temporary extension of coverage in certain instances where coverage under the plan would otherwise end, which must be offered by employers of twenty (20) or more persons.

Eligibility and Qualifying Events: The Member has the right to choose Cal-COBRA continuation coverage if any of the following qualifying events ('Qualifying Events") occurs, resulting in a loss of coverage under the group benefit plan:

1. Termination of Subscriber's employment for reasons other than gross misconduct; or

2. The reduction in hours of Subscriber's employment.

3. Covered spouses or Dependents of an employee have the right to choose continuation coverage if any of the following Qualifying Events occur:
   a) The death of the Subscriber;

   b) The termination of the Subscriber's employment (for reason's other than gross misconduct) or reduction in the hours of employment;

   c) Divorce or legal separation from the Subscriber

d) The Dependent child ceases to be a Dependent under the terms of this benefit plan; or

e) The Subscriber becomes entitled to Medicare.

Notification of Qualifying Events: An eligible Member must notify the Group if either of the following two Qualifying Events occurs resulting in a loss of coverage: (i) Subscriber's termination of employment or (ii) Subscriber's reduction in hours of employment.

With respect to all other Qualifying Events (i.e.: death, divorce, legal separation, loss of Dependent status, and entitlement to Medicare), the Subscriber or qualified beneficiary must notify the Group of the occurrence of any such Qualifying Event. This notification must be made in writing within sixty (60) days of the Qualifying Event and delivered to the Group by first class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier. Failure to provide the required notification within sixty (60) days of the Qualifying Event will disqualify the qualified beneficiary from receiving continuation coverage.

The notification should include the following information:

1. The name of the Member;

2. The Date and Type of Qualifying Event

3. Name of Employer Group and Group Plan Number

4. The name and address of all qualified beneficiaries.

Premium Payments: An eligible Member electing continuation coverage must pay to the Plan through the Group the required monthly premiums. The premium will not exceed 110% of the premium charged for active employees and/or Dependents in a comparable status. If an eligible Member is determined to be disabled for Social Security purposes, the eligible Member shall pay a premium no greater than 150% of the group rate after the first 18 months of continuation coverage. An eligible Member's first premium payment shall be delivered by certified mail, or other reliable means of delivery, to the employer within 45 days of the date the eligible Member provided written notice to the Group of the election to continue coverage. The first premium payment must satisfy all required premiums and all premiums due. Failure to submit the correct premium amount within this 45-day period will disqualify the eligible Member from receiving continuation coverage.

Election and Enrollment: When the Group is notified that one of these events has occurred, the Group will notify the Member that he or she has the right to choose continuation coverage. If the Member elects continuation coverage, the coverage will be effective on the day after coverage would otherwise be terminated. Cal-COBRA continuation coverage will be the same as the coverage provided by the Group to similarly situated employees and Dependents. Members do not have to show that they are insurable to choose continuation coverage; however, they will pay 110% of the applicable premium charged to similarly situated individuals under the Group Agreement. If they do not elect coverage and pay the appropriate premium, their benefit coverage will terminate in accordance with the provisions outlined in this Evidence of Coverage.

Termination of Cal-COBRA Coverage: Cal-COBRA continuation coverage will be terminated at the first to occur of the following:

1. In the case of a qualified beneficiary who is eligible for Cal-COBRA coverage due to the termination of employment or a reduction in hours of employment, 36 months from the date Cal-COBRA coverage commenced;

2. The end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments of a required premium;

3. In the case of a qualified beneficiary who is eligible for continuation coverage due to death, divorce or legal separation, loss of Dependent status, or entitlement to Medicare, the date36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a Qualifying Event;

4. The qualified beneficiary is no longer entitled to Cal-COBRA coverage because he or she (a) becomes eligible for Medicare; (b) becomes covered under another group benefit that does not impose any exclusions or limitations with respect to any preexisting condition; (c) becomes eligible for Federal Cal-COBRA coverage; (d) becomes eligible for coverage under the Public Health Service Act; or (e) fails to submit the correct Cal-COBRA premium amount, or fails to satisfy other terms and conditions of the plan contract.

5. The employer, or any successor employer or purchaser of the employer, ceases to provide any behavioral health group benefit coverage to his or her employees; or

6. The qualified beneficiary moves out of the Benefit Plan's service area or commits fraud or deception in the use of plan services.

A Member who is eligible for continuation coverage due to a loss of employment or reduction in hours worked, and determined, under Title II or XVI of the Social Security Act, to be disabled at any time during the first 60 days of continuation of coverage, and the spouse or dependent who has elected coverage, is eligible for 36 months of Cal-COBRA coverage, beginning from the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified Member shall notify Group of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period. Group will charge 150% of the applicable premium after the initial 18 months of continuation coverage. The qualified Member must notify Group within 30 days upon the determination that the qualified Member is no longer disabled under Title II or XVI of the Social Security Act.

Early Termination of Group Contract: If the group contract between Group and Plan is terminated prior to the date the Member's continuation coverage would terminate under Cal-COBRA, the Member may elect continuation coverage under the new group benefit plan, if any, for the remainder of the time period the Member would have been covered by Plan. If there is a new group benefit plan, the Member must contact the new benefit plan for details on continuing coverage through the plan. Please note that continuation coverage will terminate if the Member fails to comply with the requirements pertaining to enrollment in, and payment of premiums to the new benefit plan within 30 days of receiving notice by Plan of the termination of its group contract with the Member's employer.

Individuals Ineligible for Cal-COBRA: The following individuals are <u>not</u> eligible for Cal-COBRA continuation coverage:

1. Individuals who are entitled to Medicare;
2. Individuals who are covered under another group benefit that does not impose any exclusion or limitation with respect to any preexisting condition;
3. Individuals who are eligible for federal COBRA coverage;
4. Individuals who are eligible for coverage under the Public Health Service Act, such as government employees and their dependents;
5. Individuals who fail to meet the requirements set forth above relating to notification of a Qualifying Event or election of continuation coverage; and
6. Individuals who fail to submit the correct Cal-COBRA premium amount, or fail to satisfy other terms and conditions of the plan contract.

COBRA

Federal COBRA Information

Pursuant to COBRA legislation, this information will serve to advise the Member of certain rights which the Member or his/her family members may have to continuation of coverage under the Benefit Plan in the event of a termination of eligibility due to one of the following qualifying events:

1. Death of covered employee;

2. Termination of covered employee (other than for gross misconduct) or reduction in covered employee's hours of employment;

3. Divorce or legal separation of the covered employee from the employee's spouse;

4. Entitlement to Medicare benefits by the covered employee;

5. A Dependent child ceasing to be eligible for coverage as a Dependent child under the Benefit Plan.

For widows, divorced spouses, spouses of Medicare eligible employees, and Dependent children who become ineligible under the Benefit Plan, continuation coverage may be available for up to 36 months. Continuation coverage for terminated or reduced hour employees, and their eligible Dependents, may be available for up to 18 months.

A monthly premium must be paid by the Member to the Plan through his or her employer for the continuation coverage. The premium will be determined at the time of eligibility and will be subject to change; however, the premium charged to you will not exceed 102% of the premium charged for active employees and/or Dependents in a comparable status. The continuation coverage will be the same as the coverage available to continuing employees, regardless of the Member's health at the time. Coverage under COBRA must begin on the date of the qualifying event.

Continuation coverage will not be available to the Member after:

1. The Member fails to make timely premium payments; or

2. The Member or his or her spouse or Dependent is covered under any other group health plan as the result of employment, re-employment, or remarriage; or

3. The Member or his or her spouse or Dependent becomes entitled to Medicare benefits; or

4. The Member's employer or former employer ceases to maintain the Benefit Plan for employees.

At the time of eligibility for continuation coverage, an election form will be provided to the Member by his or her employer or by the plan administrator. The form must be completed and returned by the date noted. The Member or his or her eligible family member must notify the employer and the plan administrator of a divorce, legal separation, or loss of eligibility of a dependent child upon the occurrence of such event.

If a Member should have any questions about this benefit, please direct them to the Member's employer.

The Member also has the option of obtaining coverage under an individual plan.

GRIEVANCE PROCEDURES

Complaints and Disputes

Any dispute, complaint, or request for information should be directed to the Plan at the following address by certified mail, return receipt requested:

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

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 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 the disposition of the grievance.

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans. If you have a grievance against Western Dental, you should first telephone Western Dental at **1-800-992-3366**, and use Western Dental'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 Western Dental, 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 treatment 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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Website ***http://www.dmhc.ca.gov*** has complaint forms, IMR application forms, and instructions online.

Commented [CF1]: @Kristin the number you listed is another clients TFN. We need to keep the standard TFN 800-992-3366.

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 expedite the review of such grievance and immediately inform the Member of his or her right to notify the Department of the grievance. In such a situation, the Plan also will provide the Member and, as appropriate, the Department with a written statement of the status or disposition of the grievance within three days of receipt of the grievance.

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, telephone number and address of the plan representative who may be contacted about the grievance.

Independent Medical Review (IMR)

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 treatment 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 (**1-888-466O-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Website ***http://www.dmhc.ca.gov*** has complaint forms, IMR application forms, and instructions online.

Commented [CF2]: @Kristin is this TFN correct?

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with the plan and/or the Department of Managed Health Care.

OPTION (1): YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN

You may submit a grievance to Plan by calling 1-800-992-3366 or online at www.westerndental.com or by mailing your written grievance to:

WESTERN DENTAL SERVICES, INC.
P.O. Box 14227
Orange, CA 92863

You may want to submit your grievance to the Plan first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible. The Plan will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from the Plan within three (3) calendar days, or if you are not satisfied in any way with the Plan's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2): YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE

.You may submit a grievance to the Department of Managed Health Care without first submitting it to the Plan or after you have received the Plan's decision on your grievance. You may submit a grievance to the Department of Managed Health Care online at:

WWW.HEALTHHELP.CA.GOV

You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814-2725

You may contact the Department of Managed Health Care for more information on filing a grievance at:

PHONE: 1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241

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 Benefit Plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) between Member (including any heirs, successors, or assigns of Member) and 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 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 arbitrator in accordance with the comprehensive rules ("Comprehensive Rules") of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. 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 Comprehensive 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. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. 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 JAMS 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 JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

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.

MISCELLANEOUS

Coordination of Benefits

Coordination of Benefits is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. The following rules are used to determine which plan is primary and which is secondary for payment. The rules define the "Coordination of Benefits."

A. Member may be covered as an employee by his/her employer and as a dependent by his/her spouse's employer. The plan that covers the Member as an employee (the policyholder) has primary plan benefits.

B. The benefits of a program which covers a person as an active employee are determined before those of a program which covers a person as a laid-off or retired employee.

C. If spouses/dependents are covered by the Benefit Plan in another managed care program, the Participating Provider must accept the coverage that best benefits the Member.

D. If none of the above rules determine the order of benefits, the plan which has covered the employee the longest has primary plan benefits.

E. If a Member has a conversion plan with the Plan, and then obtains dental coverage through a new employer, the group plan is billed as if there were no other coverage. The conversion plan is not subject to Coordination of Benefits.

WHEN THE PLAN IS PRIMARY, the Member's Participating Provider can:

- Submit to the insurance company on a secondary basis at Participating Provider's usual and customary rates, but indicating the out-of-pocket Benefit Plan Copayment for procedures performed.
- Accept payment from the secondary insurance company equal to the Member Benefit Plan Copayments.
- Only bill the Member if the insurance pays an amount less than the Benefit Plan Copayment. The Participating Provider may bill Member for the Copayment.

WHEN THE PLAN IS SECONDARY, the Member's Participating Provider can:

- Bill primary coverage for all procedures at Participating Provider's usual and customary rates.
- When the Benefit Plan is secondary, the Participating Provider is entitled to keep all proceeds from the primary plan, but must waive the Benefit Plan Copayment if the reimbursement exceeds the Copayment responsibility. However, if the other plan benefit is less than the Copayment, the Participating Provider or the office may collect the difference from the Member.

Participation in Public Policy

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 at 800.992.3366

Filing Claims

In the event that Member requires Emergency Dental Care, Member should contact his or her Participating Provider to schedule an immediate appointment. For urgent dental conditions that occur after hours or on weekends, Member should contact the Participating Provider for instructions on how to proceed. If after contacting the Participating Provider the Member is advised that the Participating Provider is not available, Member may obtain Emergency Dental

Care from any licensed dentist in the area where such dental emergency occurs. Members may contact the Plan for assistance with obtaining an emergency appointment from a Participating Provider. Treatment by Participating Providers will be provided at the applicable Copayment listed in the Schedule of Benefits. However, there is a one hundred ($100) maximum allowable benefit for Emergency Dental Care provided by a Non-Participating Provider. The Plan requires an itemized statement of services from the Non-Participating Provider or the Member within one-hundred eighty (180) days from the date of service for verification of benefit reimbursement.

The Member must include the itemized statement of services, the Member's name, address, Member ID number**,** dates of service, treating provider's name, address**,** and telephone number, and a statement of the problem, and mail it to:

Western Dental Services, Inc.

Attn: Specialty Referrals/Claims Department

P.O. Box 14227

Orange, California 92863

The Member should retain a copy of the information, and the Plan will either send the Member a check or explain any denial within thirty (30) business days of the Plan's receipt of the Member's claim.

Confidentiality of Dental Records

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

Organ Donations

Donating organs 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 a Member is interested in organ donation, he or she should speak with his or her physician. Organ donation begins at the hospital when a Member is pronounced brain dead and identified as a potential organ donor. An organ procurement group will become involved to coordinate the activities.

Grandfathered Health Plan Status

The Plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Member’s Benefit Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive dental services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (800) 992-3366. A Member may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. A Member may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.