SERIES 7

Western Dental®
BENEFITS DIVISION

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

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

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.

The Evidence of Coverage Booklet explains your rights and responsibilities as a Western Dental Member. It also explains the Plan's responsibilities to you. 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 you 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 your employer, 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. 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 your responsibility to determine whether the dentist or specialist dentist you use is a Participating Provider. It is also your responsibility to determine whether or not a referral made by your dentist or Participating Provider is to a Participating Provider. Even though your 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 you are in doubt about the status of any dentist or facility call the Plan's Customer Service Department for verification.

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I. DEFINITIONS

A. 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 your employer or Group (Group) 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 employees or beneficiaries of Group, and their Dependents, who are eligible to participate in the Benefit Plan under the eligibility requirements, set forth by Group.

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 a prudent lay person with no special knowledge of dentistry could reasonably

expect the absence of immediate dental attention to result in:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) 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.

General Practitioners mean a dentist who practices general dentistry and who does not hold himself out to be a specialist in a particular field of dentistry.

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.

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.

Participating Provider means the Benefit Plan through its employed dentists, or a dentist under contract with the Plan as a General Practitioner 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 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 employment or other status, except for family dependency, 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.

II. ACCESS TO SERVICES

Facilities

Members may obtain a list of the Plan's Participating Providers by calling the Customer Service Department or by visit the Plan's website at **www.westerndentalbenefits.com**. 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 D9440)."

Choice of Provider

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

Each Member must receive Covered Services from a Participating Provider. A Member may designate any Participating Provider 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 Participating Provider, the Member should contact the Participating Provider to receive Covered Services

Each Member should designate the Member's Participating Provider on his or her enrollment form. If the Member does not designate a Participating Provider, the Plan will do so. If a Member wants to change Participating Providers, 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.

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.

In the event the Plan fails to pay non-contracting providers, the Member may be liable to the non-contracting provider for cost of services.

Provider Reimbursement

Services provided by a non-participating provider are not covered under the Benefit Plan. 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 might not depend on the nature or amount of services provided to a Member, as is true with capitation payments. On the other hand, the amount the Participating Provider will receive might depend entirely on the nature and amount of services provided, as happens with fee-for-service payments.

III. URGENT CARE

Emergency Care

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 dollar ($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.

IV. SECOND DENTAL OPINIONS

A Member or a Participating Provider may request a second opinion consultation by writing or calling the Plan's Customer Service 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.

V. REFERRALS

The Plan provides referral to the following specialties for covered services: Periodontics, Endodontics, Oral Surgery, and Pedodontics. If referral to a Specialist is required, a Participating Provider will initiate a referral to a Specialist on behalf of a Member. The Participating Provider 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 Customer Service Department.

PLEASE NOTE: If the request for Specialist services is not made in compliance with the foregoing, you will be responsible for the Specialist's full usual and customary fees for any such services rendered.

VI. 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 if the services were being provided by a Participating Provider at the time the provider's contract with Western Dental terminated (i.e. a "terminated provider"). Please call the Plan's Customer Service Department at (800) 992-3366 to see if you may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy from the Plan's Customer Service Department. You must make a specific request to continue under the care of your terminated provider. The Plan is not required to continue your care with your terminated provider if you are not eligible under the Plan's Continuity of Care Policy or if the Plan cannot reach agreement with your terminated provider on the terms regarding your 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. Please call the Plan's Customer Service Department at (800) 992-3366 to see if you may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy from the Plan's Customer Service Department. You must make a specific request to continue under the care of your non-Participating Provider. The Plan is not required to continue your care with your non-Participating Provider if you are not eligible under the Plan's Continuity of Care Policy or if the Plan cannot reach an agreement with your non-Participating Provider on the terms regarding your care in accordance with California law.

VII. 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 Participating Providers for specialty referrals will be made within 5 business days of the Plan's receipt of

the information that is reasonably necessary to make the determination. For urgent referrals, the decision to approve, modify, or deny requests by Participating Providers for specialty referrals will be made within 72 hours of the Plan's receipt of the information that is reasonably necessary to make the determination. The requesting Participating Provider will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to the Member verbally (when possible) and in writing within 2 business days. Upon receipt of notification of authorization, the Member may contact the Specialist to schedule an appointment. In cases where the request is retroactive, and the Member has already obtained the services from the Specialist, the Participating Provider and Member shall receive written notification for approved Specialty Referral requests no later than thirty (30) calendar days from the Plan's receipt of the information that is reasonably necessary to make the determination.

Members are also notified of their right to appeal denials in the denial notices. 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.

VIII. 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 by Group at the Plan's address set out on the first page of this Evidence of Coverage Booklet by the 25th of the month for which the Prepayment Fee applies. Member should consult Group for specific information regarding any sums to be withheld from the Member's salary or to be paid by Subscriber to the Group.

Copayments

In addition to the monthly Prepayment Fees, if any, you 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."

Liability for Payment

Refer to Section II. ACCESS TO SERVICES - Liability of Member for Payment

IX. 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 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.

The following provisions apply to all Members who are enrolled in the Benefit Plan:

Dependents shall also include all newborn infants whose coverage shall commence from the moment of birth and all adopted, foster, and step children whose coverage shall commence from the date of legal custody or placement.

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

Coverage shall not terminate while a dependent child is and continues to be: (a) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition;

or (b) Chiefly dependent upon the Subscriber for support and maintenance.

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

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

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

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.

X. COVERED SERVICES

Benefits

The Plan provides coverage to Members as set forth in this Evidence of Coverage Booklet, including the accompanying Schedule of Benefits. Such coverage will be provided when necessary for the dental health of a Member in accordance with professionally recognized standards of dental practice, subject to the Exclusions, Limitations, and other terms and conditions set out in this Evidence of Coverage Booklet. The Schedule of Benefits establishes the Covered Services which are available for no Copayment (designated as "No Copayment" in the schedule), and those services for which Members are obligated to pay a Copayment. The amount of the Copayment for specific Covered Services is set forth in the Schedule of Benefits.

The descriptive categories of Covered Services that correspond to the categories set forth in the Schedule of Benefits, together with references to Exclusions or Limitations specific to each category of services follows. To locate the specific Covered Services of this Benefit Plan for a category of services described in the Evidence of Coverage Booklet, refer to the corresponding category heading in the Schedule of Benefits.

Please Note: Refer to Sections III. and V. of this Evidence of Coverage Booklet for important information regarding the scope of Specialist services and Emergency Dental Care available under the Benefit Plan, and how to access those services.

A. Diagnostic – Clinical examinations, radiographs, and other diagnostic tools used in conjunction with the Member's health history in order to evaluate necessary dental treatment. Refer to the "Diagnostic" category on your 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 gen-

eral 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 your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

Preventive Services may include the following:

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

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

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

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

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

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

C. Restorative Services – Those procedures used to repair and restore the natural teeth to healthy condition. Refer to the "Restorative Services" category of your 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.

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 your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

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 your Schedule of Benefits to determine which specific procedures are Covered

Services and their Copayment amounts.

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.

   b) 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 your 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 your 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 your

Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

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

2. Other Surgical Procedures.

I. Orthodontic Treatment – The Plan's orthodontic benefit covers only basic orthodontic treatment to resolve malocclusion and establish optimal dental and facial esthetics. Orthodontic treatment may involve the transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan. Refer to the "Orthodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

1. Limited Orthodontic Treatment: Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem in which a decision is made to defer or forego more comprehensive therapy. An example of this type of treatment would be treatment in one arch only to correct crowding or for closure of space(s). Limited Orthodontic treatment is a benefit for treatment of Transitional, Adolescent, and Adult Dentition. Limited Orthodontic Treatment is not a Covered Service unless specifically identified in the Schedule of Benefits.

2. Comprehensive Orthodontic Treatment: The goal of the comprehensive Orthodontic treatment is improvement of the alignment of the teeth, establishment of optimal interdigitation of the upper and lower teeth, and improvement of functional and esthetic relationships of teeth and jaw. Comprehensive Orthodontic treatment is a benefit for treatment of Transitional, Adolescent, and Adult Dentition.

Orthodontic Treatment After Termination

If a Member is receiving Orthodontic treatment at the time he or she is terminated from the Plan, the Member can continue receiving care from a Participating Provider for the following continuation fee:

- If up to 12 months of treatment has been completed at the time of termination: $400.00;

- If between 12 and 18 months of treatment has been completed at the time of termination: $300.00; or

- If 18 months or more of treatment has been completed at the time of termination: $200.00.

The continuation fee is in addition to the original Orthodontic Treatment Copayment of your Benefit Plan as identified in the Schedule of Benefits. Members will be given the opportunity to pay the continuation fee over the remaining period of treatment. This continuation fee, as well as any outstanding balance at the time of termination, is payable to the Participating Provider. If the Member relocates to an area outside the geographic area served by the Plan, and is unable to receive treatment from a Participating Provider, continuing orthodontic coverage under the Plan ceases and the Member will have no further Orthodontic benefit from the Plan. (Copayments for retention and post-treatment records are still applicable.)

XI. TERMINATION, RESCISSION AND CANCELLATION OF COVERAGE

Termination of Benefits

A. Upon termination of a Subscriber's employment or membership with the Group, Member, as well as his/her Dependents, shall continue to be eligible to receive services until the last day of the month in which the Subscriber's termination occurred (See section XIV 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 canceled or not renewed because of his/her health status or requirements for services may request review by the Director of the Department of Managed Health Care.

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

1. If Member knowingly provides false information on his or her enrollment form, or fraudulently uses services or facilities of the Plan or providers, or knowingly allows another person to do so. Termination is effective immediately on the date the Plan mails notice of termination.

2. If Member threatens Plan employees, providers, Members or other patients, or engages in repeated behavior that substantially impairs the Plan's ability to provide services to the Member or substantially impairs the ability of the Plan or a provider to provide services to other Members or patients. Termination is effective 15 days after notice is sent to Member.

   If coverage is terminated for any of the above reasons, 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.

Note: If the Agreement with your 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.

D. 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 Section X. COVERED SERVICES.

E. When the Agreement between Western Dental and Group is terminated, all Members covered under the Agreement become ineligible for coverage. The Agreement between Western Dental

and Group may be terminated in any of the following circumstances:

- Failure to Pay Prepayment Fees. Group fails to pay any Prepayment Fee when due under the Agreement. The Plan will provide the Group with 15 days notice before cancellation of the Agreement for non-payment. Termination is effective as of the 15th day after the notice.

- Fraud or Deception in Use of Services. Group engages in fraud or deception in the use of the services or facilities of Western Dental, 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 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 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.

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 you if and when the Agreement is terminated for any reason, including the non-payment of Prepayment Fees, and for providing you with a copy of the notice of termination provided to the Group by the Plan.

F. Upon termination of a Participating Provider's contract, the Plan shall be liable for Covered Services rendered by such Participating Provider, other than for Copayments and excluded services, to a Member who retains eligibility under the Agreement or by operation of law, and who was under the care of such Participating Provider at the time of such termination, until the services being rendered to the Member by such Participating Provider are completed, unless the Plan makes reasonable and dentally appropriate provisions for the assumption of such services by a Participating Provider.

XII. 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 may terminate the Agreement by giving the other party 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. During the term of the contract, Plan may not increase the Prepayment Fee, the Copayment amounts paid by the Members, or decrease the Covered Services in any manner during a contract term without a prior written agreement between Group and Plan.

XIII. 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 Subscriber 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 your Federal COBRA coverage began on or after January 1, 2003 and you have exhausted your Federal COBRA benefits, you 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 your former employment. A notice will be provided to you at the time your COBRA benefits will exhaust, allowing up to 18 more months, but not to exceed 36 months from the date your 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 oth-

erwise 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 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 your continuation coverage would terminate under Cal-COBRA, you may elect continuation coverage under the new group benefit plan, if any, for the remainder of the time period you would have been covered by Plan. If there is a new group benefit plan, you must contact the new benefit plan for details on continuing coverage through the plan. Please note that continuation coverage will terminate if you fail 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 your employer.

Individuals Ineligible for Cal-COBRA: The following individuals are not 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.

XIV. COBRA

Federal COBRA Information

Pursuant to COBRA legislation, this information will serve to advise you of certain rights which you or your 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 you to the Plan through your employer for the continuation coverage. The premium will be determined at the time of eligi-

bility 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 your health at the time. Coverage under COBRA must begin on the date of the qualifying event.

Continuation coverage will not be available to you after:

1. You fail to make timely premium payments; or

2. You or your spouse or Dependent is covered under any other group health plan as the result of employment, re-employment, or remarriage; or

3. You or your spouse or Dependent becomes entitled to Medicare benefits; or

4. Your 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 you by your employer or by the plan administrator. The form must be completed and returned by the date noted. You or your eligible family member must notify your 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 you should have any questions about this benefit, please direct them to your employer.

You also have the option of obtaining coverage under an individual plan.

XV. GRIEVANCE PROCEDURES

Complaints and Disputes

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

WESTERN DENTAL SERVICES, INC.
P.O. Box 14227
Orange, CA 92863
Telephone calls should be made to the Plan at the following number:
(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 Department of Managed Health Care 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and

speech impaired. The department's Internet Website ***http://www.hmohelp.ca.gov*** has complaint forms, IMR application forms, and instructions online.

A Member may submit a complaint or grievance to the Department for review after the Member has participated in the Plan's grievance process for at least 30 days.

If the Member's grievance involves an imminent and serious threat to his or her health–including but not limited to, severe pain, potential loss of life, limb, or major bodily functions–the Member may submit the grievance to the Department without waiting 30 days. In such a situation, the Plan will immediately inform the Member of his or her right to notify the Department of the complaint. 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 complaint within three days of receipt of the complaint.

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

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 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.

XVII. 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. If a child is covered as a dependent under both parents' coverage (and parents are not separated or divorced), the plan of the parent with the earliest birthday in the year has primary responsibility for plan benefits.

C. If a child of divorced or separated parents is covered as a dependent under the parents' coverage, benefits are determined in this order:

    1. The parent's plan that has custody of the child.

    2. The spouse's plan of the parent who has custody of the child.

    3. The parent's plan not having custody of the child.

D. 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.

E. 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.

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

G. 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, Your 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, Your 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.

XVIII. 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 Customer Service Department at 1-800-992-3366

XIX. 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 dollar ($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.

XX. CONFIDENTIALITY OF MEDICAL (DENTAL) RECORDS

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

XXI. 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 you are interested in organ donation, please speak with your 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.

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Western Dental®

BENEFITS DIVISION

530 South Main Street
Orange, CA 92868

Customer Service: 800-992-3366
www.westerndentalbenefits.com

Form 7079 Rev.1 (10/08)