WELCOME TO WESTERN DENTAL

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

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

The Plan welcomes Member participation on its Public Policy Committee, which meets quarterly at the Plan’s corporate offices in Orange, California. In order to be considered for membership, please write or call the Plan’s Member Services Department at 1-800-992-3366.

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

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

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

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

I. DEFINITIONS  
II. COMMENCEMENT DATE  
III. IDENTIFICATION CARD  
IV. PREPAYMENT FEE  
V. ELIGIBILITY  
VI. BENEFITS  
VII. COPAYMENTS AND OTHER CHARGES  
VIII. SPECIALIST REFERRALS  
IX. EMERGENCY CARE AND REIMBURSEMENT  
X. LIMITATIONS  
XI. EXCLUSIONS  
XII. CHOICE OF PROVIDER  
XIII. FACILITIES  
XIV. LIABILITY OF MEMBER FOR PAYMENT  
XV. RENEWAL PROVISIONS  
XVI. TERMINATION OF BENEFITS  
XVII. COMPLAINTS AND DISPUTES  
XVIII. GRIEVANCE PROCEDURES  
XIX. ARBITRATION  
XX. GENERAL PROVISIONS  
XXI. ORGAN & TISSUE DONATION  

SCHEDULE OF BENEFITS
I. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. COMMENCEMENT DATE

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

III. IDENTIFICATION CARD

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

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

V. ELIGIBILITY

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

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

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

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

3. Coverage for an enrolled Dependent child shall not terminate while he or she is and continues to be: (a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and, (b) chiefly dependent upon the Subscriber for support and maintenance, provided the Subscriber furnishes proof of such incapacity and dependency to the Plan within 31 days of the Dependent attaining the limiting age as set forth in Section V.B.2. of this Agreement and Evidence of Coverage, and every two years thereafter.

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

VI. BENEFITS

This Benefit Plan is intended to provide services that fall within the scope of general dentistry practice. General dentistry services are dental procedures that may be performed by a dentist who has not received advanced specialty training. Specialty care is covered only when a Covered Service and provided by a Participating Provider in a Western Dental Center. Not all Participating Providers are able to provide specialist services, and some specialty services are not available in some Western Dental Centers. If a Member requires specialty services not available from a Participating Provider in the Member’s assigned Western Dental Center, the Participating Provider will refer the Member to another Participating Provider who can provide the specialty service. In addition, a Participating Provider able to perform a particular service may refer the Member to another specialist if clinically appropriate based on the individual Member’s medical and dental condition. If you require a specialty service, please ask the staff at your assigned Western Dental Center for the nearest Participating Provider that can provide that service. Specialty services are not covered if performed by a non-Participating Provider. If you have a question regarding the availability of a specialist service at a particular Western Dental Center, please contact the Plan.

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

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

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

1. Comprehensive Oral Evaluation – A comprehensive evaluation of a Member’s dental health needs. This includes evaluating and recording a Member’s dental and medical history and a general health assessment, including such things as dental caries, missing or un-erupted teeth, restorations, occlusal relationship, periodontal conditions (including periodontal charting), and hard and soft tissue anomalies.
2. **Limited Oral Evaluation** – An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Typically, Members receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

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

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

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

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

   1. **Prophylaxis (Adult and Child)** – These cleanings include scaling and polishing of the crown portion of exposed teeth in the mouth and is the treatment for the removal of stain, plaque, and calculus (tartar) above the gum line. It is not intended to be treatment for active periodontal disease where subgingival (beneath the gum line) scaling and root planing is usually required.
   2. **Topical Fluoride Treatment** – Application of topical fluoride to aid in the prevention of caries formation.
   3. **Nutritional Counseling for Control of Dental Disease** – Counseling on food selection and dietary habits as a part of the treatment and control of periodontal disease and caries.
   4. **Oral Hygiene Instruction** – Instructions for home care. Examples include tooth brushing technique, flossing, and use of special oral hygiene aids.
      
      **Exclusion:** The Benefit Plan does not cover supplies used for oral hygiene and plaque control, such as dental floss, toothbrushes, tongue scrapers, fluoride products, toothpaste, mouth rinse, disclosing agents, and interproximal brushes.
   5. **Sealants** – The application of sealants to pit and fissure areas as a measure in the prevention of caries.
   6. **Space Maintenance** – passive appliances designed to prevent tooth movement.

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

   1. **Amalgam and Resin-Based Composite Restorations** – Those procedures that include amalgam or resin-based composite restorative material used in order to repair and restore the natural teeth to healthy condition.
   2. **Crowns – Single Restoration Only** – Those procedures that include gold, ceramic, porcelain and porcelain fused to metal in covering the tooth.
      
      **Exclusions:**
      a) Crowns that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered.
      b) Implant supported crowns and abutment supported crowns on a dental implant are not a Covered Service.
   3. **Other Restorative Services** –
      a) Re-cementation of crowns – Use of adhesive material to reattach a crown that is dislodged.
      b) Prefabricated Stainless Steel and Resin Crowns
      c) Sedative filling – Temporary restoration intended to relieve pain.
      d) Post and core buildup – Material placed within the root canal or in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.
      e) Labial Veneer (Porcelain Laminate) – A thin layer of porcelain or ceramic restoration that is bonded to the facial surface (the surface of a tooth oriented toward the face) of a tooth by means of a resin adhesive.
D. ENDODONTICS – Those procedures that involve treatment of the pulp, root canal and roots.

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

Exclusions:

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

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

Limitation:

Endodontic services that are beyond the scope of general dentistry practice are not Covered Services. Examples include, without limitation, root canal treatment of teeth with dilacerated roots, calcified canals, obstructed canals, open apices, and external or internal root resorption.

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

1. Periodontal Services (Surgical). The following Periodontal Services (Surgical) are Covered Services if performed by a Participating Provider.
   a) Gingivectomy – Removal of part of the gingival margin resulting in exposure of more tooth structure.
   b) Crown Lengthening – Surgical procedure involving the removal of gingiva and supporting bone to expose more tooth structure in preparation for a crown procedure.

Exclusions:

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

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

Limitations:

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

2. Periodontal Services (Non-surgical)
   a) Scaling and Root Planing - Instrumentation of the crown and root surface of the teeth to remove plaque, calculus (tartar), and contaminated connective tissue from these surfaces.
   b) Full Mouth Debridement – Removal of plaque and calculus that obstruct the ability to perform an evaluation.
   c) Provisional Splinting (extracoronal) – An interim stabilization of mobile teeth.
   d) Periodontal Maintenance – Maintenance of periodontal health of patients who have undergone active surgical or nonsurgical periodontal therapy.
   e) Emergency Periodontal Treatment – Treatment provided to treat acute pain of periodontal origin.
   f) Localized Delivery of Chemotherapeutic Agents – Use of controlled release chemotherapeutic agents as an adjunctive procedure for reduction of subgingival flora.

Limitation:

Treatment, evaluation, and planning for periodontal services that are beyond the scope of general dentistry are not covered.
F. PROSTHODONTICS, REMOVABLE—Replacement of lost teeth by a removable prosthesis and the maintenance of those appliances.

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

Exclusions:

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

Limitation:

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

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

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

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

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

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

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

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

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

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

Exclusions:

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

2. Fixed Partial Denture Services—

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

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

**Limitation:**

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

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

   a) **Biopsy (Soft Tissue)** – The process of removing tissue for histologic evaluation.
   b) **Tuberosity Reduction** – The process of reshaping of the posterior portion of the maxillary alveolar ridge.
   c) **Removal of Tori and Exostosis** – The process of removal of overgrown bony protuberances.
   d) **Intraoral Incision and Drainage (I & D)** – The process of drainage of an abscess through an incision.
   e) **Frenectomy** – The process of elimination of muscle fibers attaching the cheek, lips, and tongue to associated dental mucosa.
   f) **Excision of Hyperplastic Tissue** – The process of removing overgrown soft tissue from the oral cavity.
   g) **Alveoloplasty** – Reshaping the bond supporting a dental prosthesis.

**Exclusions:**

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

**Limitation:**

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

---

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

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

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

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

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

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

The following services are not covered under the Benefit Plan:

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

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

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

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

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

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

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

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

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

Continuing Orthodontic Treatment After Termination

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

VII. COPAYMENTS AND OTHER CHARGES

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

VIII. SPECIALIST REFERRALS

Specialty care identified as a Covered Service in this Agreement and Evidence of Coverage and Schedule of Benefits is covered only when rendered by a Participating Provider in a Western Dental Center. When specialty care that is not a Covered Service is deemed appropriate for the Member, Participating Providers will refer the Member to a specialist or specialists to obtain specialty care, but any specialty services provided by a non-Participating Provider are not Covered Services.

IX. EMERGENCY CARE AND REIMBURSEMENT

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

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

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

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

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

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

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

1. Complete and Partial Dentures
   Over-dentures are not covered unless specifically listed on the attached Schedule of Benefits.

2. Tooth Additions and Repair to Existing Denture
   Repair of appliances damaged due to Member abuse is not covered.

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

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

2. Other Surgical Procedures
   All surgical procedures that are beyond the scope of general dentistry practice are not covered.

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

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

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

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

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

F. SPECIALIST SERVICES – Specialty care is covered only when a Covered Service and provided by a Participating Provider in a Western Dental Center. Not all Participating Providers are able to provide specialist services, and some specialty services are not available in some Western Dental Centers. If a Member requires specialty services not available from a Participating Provider in the Member’s assigned Western Dental Center, the Participating Provider will refer the Member to another Participating Provider who can provide the specialty service. In addition, a Participating Provider able to perform a particular service may refer the Member to another specialist if clinically appropriate based on the individual
Member’s medical and dental condition. If you require a specialty service, please ask the staff at your assigned Western Dental Center for the nearest Participating Provider that can provide that service. Specialty services are not covered if performed by a non-Participating Provider. If you have a question regarding the availability of a specialist service at a particular Western Dental Center, please contact the Plan.

XI. EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

H. ORTHODONTICS (Braces)
The following services are not covered under the Benefit Plan:
1. Extractions for Orthodontic Purposes - Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space is not covered.
2. TMJ/Myofunctional Therapy - Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture are not covered.

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

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

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

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

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

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

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

I. GENERAL EXCLUSIONS

1. Treatment by someone other than a Participating Provider and/or duly qualified technician under the direction of a Participating Provider except for Emergency Care as provided in Section IX, or upon prior authorization by the Plan, is not a Covered Service.

2. Charges for medical treatment, prescriptions, or other non-dental charges incurred are not covered.

3. Hospitalization costs for any dental procedure, including all hospital services and medications, dental services that are delivered in an inpatient or outpatient hospital setting, and all other associated expenses, including general anesthesia and IV conscious sedation, remain the responsibility of the Member.

4. General anesthesia and IV conscious sedation are not covered, whether provided in a hospital or any other setting.

5. Treatment of malignancies, neoplasms, and cysts is not covered.

6. Treatment of disturbances of the Temporomandibular Joint (TMJ) is not covered.

7. Procedures, restorations, and appliances to correct congenital or developmental malformations are not covered.

8. Dental expenses incurred in connection with any dental procedure started after termination of coverage are not covered.

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

10. Unless specifically identified in the Schedule of Benefits, no dental service is covered, including without limitation, the following: diagnostic services for general dentistry, preventative, restorative, endodontic, periodontic, prostodontics (fixed or removable), and oral surgery services.

11. Drugs are not covered unless administered by a Participating Provider during the course of treatment for a Covered Service.

12. Further treatment of a Covered Service may be discontinued if the Member continually fails to follow the prescribed course of treatment, and, in such cases, further treatment is not covered.

XII. CHOICE OF PROVIDER

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

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

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

Services provided by a non-Participating Provider are not covered under the Benefit Plan. Participating Providers are employees of the Plan. The Plan pays each Participating Provider a set amount for each day he or she works. The Plan will not pay a bonus to anyone to deny, reduce, limit, or delay the provision of Covered Services that a Member is entitled to receive.
Upon termination of a Participating Provider, the Plan shall be liable for Covered Services rendered by such Participating Provider, other than for Copayments and excluded services, to a Member who retains eligibility under the Agreement and Evidence of Coverage or by operation of law, and who was under the care of such Participating Provider at the time of such termination, until the services being rendered to the Member by such Participating Provider are completed, unless the Plan makes reasonable and dentally appropriate provisions for the assumption of such services by a Participating Provider.

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

SECOND DENTAL OPINIONS

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

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

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

XIII. FACILITIES

Members may obtain a Provider Directory by calling the Member Services Department at (800) 992-3366. Western Dental Centers are generally open during normal business hours. Should a Member have a question regarding the days and/or hours of a Western Dental Center, he/she may write or call the Western Dental Center at the address and telephone number specified in the Provider Directory. A copy of the Provider Directory is also included in the enrollment package.

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

XIV. LIABILITY OF MEMBER FOR PAYMENT

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

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

XV. RENEWAL PROVISIONS

This Agreement and Evidence of Coverage remains in effect for one year and automatically renews unless it is terminated or not renewed as provided in the Termination of Benefits Section.

XVI. TERMINATION OF BENEFITS

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

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

C. The Plan is not required to renew or reinstate the Agreement and Evidence of Coverage if the Plan no longer offers the Benefit Plan set forth in this Agreement and Evidence of Coverage and Schedule of Benefits. Termination shall be effective at midnight of the last day of the enrollment period purchased by any previously paid Prepayment Fee. If the Agreement and Evidence of Coverage is not renewed or reinstated because the Plan no longer offers the Benefit Plan, Members have the right to enroll in an alternate benefit plan offered by the Plan without penalty.

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

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

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

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

**XVII. COMPLAINTS AND DISPUTES**

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

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

**XVIII. GRIEVANCE PROCEDURES**

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against the Plan, you should first telephone the Plan at 1-800-992-3366 and use the Plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site [http://www.hmohelp.ca.gov](http://www.hmohelp.ca.gov) has complaint forms, IMR applications forms, and instructions online.

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

XIX. ARBITRATION

Any and all disputes of any kind whatsoever, including, but not limited to, claims for dental malpractice (that is as to whether any dental services rendered under the Plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) between Member (including any heirs, successors, or assigns of Member) and the Plan, except for claims subject to ERISA, shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Member and the Plan are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single 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.

XX. GENERAL PROVISIONS

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

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

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

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

The terms of any contract shall not be modified and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reduction, co-payments, co-insurance, deductibles, reservations, or premium, price or charge differentials, or other modifications because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, or any physical or mental impairment of any contracting party, prospective contracting party, or person reasonably expected to benefit from any such contract as a Member or otherwise; except that premium, price or charge differentials because of the sex or age of any such individual and based on objective, valid and up-to-date statistical and actuarial data are not prohibited.
E. This Plan does not provide any exception for other coverage where the other coverage is entitlement to: (i) Medi-Cal benefits under Chapter 7 or Chapter 8 of Part 3 of Division 9 of the California Welfare and Institutions Code; or (ii) Medicaid benefits under Subchapter 19 of Chapter 7 of Title 42 of the United States Code. This Plan also does not provide an exemption for enrollment because a Member is entitled to Medi-Cal or Medicaid benefits.

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

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

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

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

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

XXI. ORGAN & TISSUE DONATION

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

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