EVIDENCE OF COVERAGE BOOKLET

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 EVIDENCE OF COVERAGE BOOKLET CONSTITUTES ONLY A SUMMARY OF THE BENEFIT PLAN. THE 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 Member Services Department 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.

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.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Western Dental's Customer Service Department, toll-free, at 1-800-992-3366 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

MULTILINGUAL SERVICES

If you or your representative prefer to speak in any language other than English, please call Western Dental, toll-free, at 1-800-992-3366 to speak with a Western Dental Customer Service Representative Our Customer Service staff can help you find a Participating Provider who speaks your language or who has a regular interpreter available. You do not have to use a family member or friends as interpreters. If you cannot locate a Participating Provider who meets your language needs, you can request to have an interpreter available for discussions of medical information at no charge.

This EOC booklet, as well as other information materials, has been translated into Spanish. To request translated materials, please call Western Dental, toll-free, at 1-800-992-3366.

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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.

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

C. "Agreement" means the Group Subscriber Agreement between San Diego Unified School District and the Plan.

D. "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.

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

F. "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.

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

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

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

J. "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.

K. "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:

1. 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;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

M. "General Practitioner" means a dentist who practices general dentistry and who does not hold himself out to be a specialist in a particular field of dentistry.

N. "Group" means San Diego Unified School District who has contracted with the Plan to provide the Covered Services described in this Evidence of Coverage Booklet.

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

P. "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.

Q. "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.

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

S. "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.

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

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

V. "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.

W. "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.

X. "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.

Y. "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. COMMENCEMENT DATE

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.

III. 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.

IV. ELIGIBILITY

A. 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.

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

    1. 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.

2. Effective January 1, 2011, Western Dental will honor a Group's decision to extend dental coverage under this plan to qualified dependents up to age 26 pursuant to federal health care reform laws, even though such federal health care laws do not require dental plans to so extend the dependent coverage age. Please check with your Group to determine if it is providing such extended coverage to dependents for dental benefits.

3. Coverage shall not terminate while a Dependent child is and continues to be: (a) Incapable if self-sustaining employment by reason of handicap 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 sixty (60) days of receipt of the request. The child must have been covered as a dependent of the Subscriber or spouse under a previous health plan at the time the child reached the age limit.

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

V. 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 Cost" 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. Additional Exclusions and Limitations are set forth in the "Exclusions" and "Limitations" Sections of this Evidence of Coverage Booklet, which must also be consulted to determine the extent of Covered Services.

Please Note: Refer to Sections VII. and VIII. 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 general health assessment, including such things as dental caries, missing or un-erupted teeth, restorations, occlusal relationship, periodontal conditions (including periodontal charting), and hard and soft tissue anomalies.

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

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

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

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

5. Radiographs/Diagnostic Imaging – Radiographs are primarily for clinical purposes; they represent an important diagnostic aide. A radiographic exam is a combination of periapical, bitewing, panoramic films or other views selected for a Member based on need. The number and type of radiograph in any examination will vary according to the needs of the Member.

   Limitation: Full mouth X-rays are limited to only once in a two-year period. Bitewing X-rays are limited to one series of four in any six-month period, unless additional X-rays are determined by the treating Participating Provider to be necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

B. PREVENTIVE – 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.

   Limitation: Prophylaxis cleanings are covered once every six months at Benefit Plan Copayments, unless additional cleanings are necessary for the dental health of a Member in accordance with professionally recognized standards of dental practice.

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

   Limitation:
   a) Topical Fluoride is not a benefit for Members over the age of 19 years, unless the treating Participating Provider determines topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.
   b) Topical Fluoride Treatments are limited to one treatment in a 6 consecutive month period, unless the treating Participating Provider determines additional topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

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.

   Limitation: Sealants are not a benefit for Members over the age of fifteen (15) years unless the treating Participating Provider determines sealants are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

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.

   Member will pay an additional copayment of $150.00 for placement of porcelain on a molar tooth.

   Exclusions:

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

   Limitations:

   a) Crowns are not covered when a filling can

adequately restore the dental health of a Member in accordance with professionally recognized standards of dental practice.

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

c) Precious metal crowns are not covered unless specifically listed as a Covered Service of your Benefit Plan. The Member must pay an additional copayment for the noble metal or the high noble metal. (See attached Schedule of Benefits for detailed information.)

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.

Limitation: Posts or pins are not covered except where insufficient coronal structure remains to retain restoration.

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.

   Exclusions:

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

   a) Crown Lengthening – Surgical procedure involving the removal of gingiva and supporting bone to expose more tooth structure in preparation for a crown procedure.
   b) Bone Grafts – Use of various forms of graft to stimulate bone formation.
   c) Soft Tissue Graft – Use of gingiva as a graft to repair a gingival defect or an exposed root.

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.

Limitation: Subgingival Scaling and Root Planing is covered once every six months, unless necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

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.

   Exclusions:

   a) Lost, stolen, or damaged appliances, due to Member abuse are not covered.
   b) Removable Prosthetic Services and supplies that are cosmetic in nature.
   c) Implant supported prostheses are not covered.
   d) Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances are not covered.
   e) Overdentures (dentures that overlie, and are supported by, a retained tooth root or a dental implant) are not covered.

   Limitations:

   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.

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

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

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

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.

   Member will pay an additional copayment of $150.00 for placement of porcelain on a molar tooth.

   Exclusions:

   a) Fixed Partial Dentures that are lost, stolen, or damaged due to Member abuse are 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.

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

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

g) Fixed Partial Dentures are not covered if abutment teeth are healthy and would be crowned only for the purpose of supporting a pontic. If Fixed Partial Dentures are used under these circumstances, it is considered elective and is not a Covered Service, and the Member must pay the Participating Provider's charges that exceed the Copayment for a Removable Partial denture as specified in the Schedule of Benefits. This exclusion does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

Limitations:

a) Replacement of an existing appliance will be covered if the appliance is over five years old. Replacement of appliances that are less than five years old is covered only if appliance was originally provided while the Member was not covered under any Western Dental Benefit Plan, or if replacement is required as a result of clinically defective dentistry.
b) Precious metal Fixed Partial Dentures are not covered unless specifically listed as a Covered Service of your Benefit Plan in your Schedule of Benefits or the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice. The Member must pay an additional copayment for the noble metal or the high noble metal. (See attached Schedule of Benefits for detailed information.
c) Stress Breaker (non-rigid connector between the abutment and the pontic) is not covered unless specifically listed as a Covered Service of your Benefit Plan in your Schedule of Benefits or the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

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.

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

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.

   Limitation: Extractions are not covered when the procedure is performed to remove teeth that are not diseased or otherwise unrestorable, except Extractions for orthodontic purposes which are limited to removal at a Western Dental Center when the treatment can be performed at a Western Dental Center office, at the discretion of the Western Dental Center dentist.

2. Other Surgical Procedures

   Exclusions: The following Oral Surgery procedure is not covered unless specifically identified as Covered Services in the Schedule of Benefits.

   a) Tuberosity Reduction – The process of reshaping of the bone supporting a dental prosthesis.

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 primary, 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 Primary, Transitional, Adolescent, and Adult Dentition.

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.

The following services are not included in the Limited Orthodontic Treatment, Interceptive Orthodontic Treatment, or Comprehensive Orthodontic Treatment Copayments, however they are Covered Services as specifically identified in the Schedule of Benefits with an applicable copayment.

1. Start-up Services – Including preparation of orthodontic records consisting of x-rays, cephalometric x-rays, tracings, and case study models, are not included in the Limited, Interceptive or Comprehensive Orthodontic Treatment Copayments. The Member's Schedule of Benefits identifies a Start-up Services Copayment, and the Member must pay the Copayment for Start-up Services. (See attached Schedule of Benefits for detailed information.)

2. Retention-Retainers to hold and monitor the teeth following orthodontics (braces) are not included in the Limited, Interceptive or Comprehensive Orthodontic Treatment Copayments. The Member's Schedule of Benefits identifies a Retention Fee Copayment and the Member must pay the Copayment for the Retention Services. (See attached Schedule of Benefits for detailed information.)

3. 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 Limited, Interceptive or Comprehensive Orthodontic Treatment Copayments. Failure to attend required appointments, failure to maintain proper oral hygiene, and failure to wear appliances as instructed by the orthodontist are examples of gross non-cooperation for which the Member would be subject to additional charges that will not be covered by the Limited, Interceptive or Comprehensive 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 Limited, Interceptive or Comprehensive Orthodontic Treatment Copayment, as set forth in the Schedule of Benefits, divided by the number of months in the original treatment plan.

4. Post-treatment Records - x-rays, photographs and models following orthodontic treatment are not included in the Limited or Comprehensive Orthodontic Treatment Copayments. The Member's Schedule of Benefits identifies a Post-Treatment Fee Copayment and the Member must pay the Copayment for the Post-Treatment Services. (See attached Schedule of Benefits for detailed information.)

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.)

Orthodontic Limitations and Exclusions

The following services are *limited* or not covered under the orthodontic benefit or elsewhere in the Benefit Plan:

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

2. Surgical Orthodontics – Surgical Orthodontics to reposition the jaw bones and teeth is not covered.

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

4. Orthognathic Surgery- Surgery to move the jaw bones into alignment is not covered.

5. 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 are 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.

10. Lost, Stolen, Damaged or Broken Appliances - Damaged or lost retainers, brackets, bands, wires or other materials supplied by the orthodontist are not covered.

11. Extractions for Orthodontic Purposes — Extractions are covered only when they can be performed at a Western Dental Center office, at the discretion of the Western Dental Center office dentist.

VI. 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."

VII. SPECIALIST 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.

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.

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.

VIII. EMERGENCY DENTAL CARE REIMBURSEMENTS

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) per emergency 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.

IX. LIMITATIONS

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

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

Full Mouth X-Ray/Bite Wing X-Ray –

1. Coverage for full-mouth X-ray is limited to once in a two-year period.

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

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

Prophylaxis

The Plan provides coverage for these "teeth cleanings" only once every six (6) months. If applicable, the Copayment for each cleaning is specified in the Schedule of Benefits. An additional prophylactic cleaning will be covered if the treating Participating Provider deems it necessary for the dental health of the Member, consistent with professionally recognized standards of dental practice. Some examples of situations where additional prophylaxes may be necessary for the dental health of the Member are:

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

5. Leukemia or HIV induced gingivitis.

Fluoride Treatments

a) Topical Fluoride is not a benefit for Members over the age of 19 years, unless the treating Participating Provider determines topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.
b) Topical Fluoride Treatments are limited to one treatment in a 12 consecutive month period , unless the treating Participating Provider determines additional topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

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

Crowns

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

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

3. Precious metal crowns – use of precious metal in fabrication of a crown requires an additional copayment for the noble metal or the high noble metal. (See attached Schedule of Benefits for detailed information.)

Other Restorative Services

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

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

Subgingival Scaling and Root Planing

This procedure is covered once every twelve months, unless necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

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

Complete and Partial Dentures

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

Tooth Additions and Repair to Existing Denture

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

Denture Reline and Rebase

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

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

Fixed Partial Dentures, Pontics, and Crowns

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

required as a result of clinically defective dentistry.

2. Precious metal Fixed Partial Dentures require an additional copayment for the noble metal or the high noble metal. (See attached Schedule of Benefits for detailed information.)
3. Stress Breaker (non-rigid connector between the abutment and the pontic) is not covered unless specifically listed as a Covered Service of your Benefit Plan in the Schedule of Benefits or the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

Fixed Partial Dentures Services

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

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

Extractions for orthodontic purposes are *limited* to removal at a Western Dental Center when the treatment can be performed at a Western Dental Center office, at the discretion of the Western Dental Center dentist.

H. Orthodontics - The following services are not included in the Limited Orthodontic Treatment, Interceptive Orthodontic Treatment, or Comprehensive Orthodontic Treatment Copayments, and they are not Covered Services unless specifically identified in the Schedule of Benefits.

1. Start-up Services – Including preparation of orthodontic records consisting of x-rays, cephalometric x-rays, tracings, and case study models, are not included in the Limited or Comprehensive Orthodontic Treatment Copayments. The Member's Schedule of Benefits identifies a Start-up Services Copayment and the Member must pay the Copayment for Start-up Services. (See attached Schedule of Benefits for detailed information.)

2. Retention-Retainers to hold and monitor the teeth following orthodontics (braces) are not included in the Limited, Interceptive, or Comprehensive Orthodontic Treatment Copayments. The Member's Schedule of Benefits identifies a Retention Fee Copayment and the Member must pay the Copayment for the Retention

Services. (See attached Schedule of Benefits for detailed information.)

3. Services Required Because of Gross Non-Cooperation – Additional 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 Limited, Interceptive, or Comprehensive Orthodontic Treatment Copayments.

   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 Limited, Interceptive, or Comprehensive Orthodontic Treatment Copayment, as set forth in the Schedule of Benefits, divided by the number of months in the original treatment plan.

4. Post-treatment Records - x-rays, photographs and models following orthodontic treatment are not included in the Limited, Interceptive, or Comprehensive Orthodontic Treatment Copayments. The Member's Schedule of Benefits identifies a Post-Treatment Fee Copayment and the Member must pay the Copayment for the Post-Treatment Services. (See attached Schedule of Benefits for detailed information.)

I. Specialist Referrals – Prior authorization from the Plan is required for coverage of dental services provided by a Specialist. Please refer to the Specialist Referrals Section of this Evidence of Coverage Booklet. Referral to a participating Pedodontist Specialist for children under the age of six years is available and must be pre-authorized by the Plan.

X. EXCLUSIONS

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

A. Preventive

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

B. Restorative Services

1. Crowns that are cosmetic in nature are not covered.
2. Crowns that are lost, stolen, or damaged when due to Member abuse, misuse or neglect.
3. Implant supported crown and abutment supported crowns on a dental implant are not Covered Service.
4. Porcelain, composite or acrylic crown restorations posterior to the second bicuspid, are considered purely cosmetic dentistry and require an additional copayment. (See attached Schedule of Benefits for detailed information.)

C. Periodontics

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

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

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

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

D. Prosthodontics, Removable

1. Lost, stolen, or damaged appliances due to Member abuse is not covered.
2. Removable Prosthetic Services and supplies that are cosmetic in nature.
3. Implant supported prostheses are not a Covered

Service.

4. Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances are not covered.
5. Overdentures (dentures that overlie, and are supported by, a retained tooth root or a dental implant) are not covered.

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

1. Lost, stolen, or damaged Fixed Partial Dentures , due to Member abuse is not covered.
2. Distal extension posterior cantilever pontics, which are supported at the front end only, are not covered.
3. Implant supported prostheses are not a Covered Service.
4. Correction of Occlusion or "occlusal equilibration" when performed independently of a completed restoration of a prosthesis may be recommended to treat Temporomandibular Joint Disorders (TMJ) or Myofacial pain. In such instances, correction of occlusion is not covered, since this Benefit Plan does not cover treatments of disturbances of the TMJ.
5. Facing on pontics and crowns posterior to the second bicuspid are considered to be cosmetic and require an additional Copayment. (See attached Schedule of Benefit for detailed information.)
6. Fixed Partial Dentures are not covered if the Member is missing teeth on opposite sides of the same arch, because a Removable Partial Denture is considered an adequate replacement. If the Member elects to receive a Fixed Partial Denture, the Member must pay the Participating Provider's charges that exceed the Copayment for a Removable Partial Denture as set forth in the Schedule of Benefits. This exclusion does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.
7. Fixed Partial Dentures are not covered unless a Removable Partial Denture cannot satisfactorily restore the case according to professionally recognized standards of dental practice. This limitation does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.
8. Fixed Partial Dentures are not covered when abutment

teeth are healthy and would be crowned only for the purpose of supporting a pontic. If Fixed Partial Dentures are used under these circumstances, it is considered elective and is not a Covered Service, and the Member must pay the Participating Provider's charges that exceed the Copayment for a Removable Partial denture as specified in the Schedule of Benefits. This limitation does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

F. Oral Surgery: The following surgical procedures are not covered unless specifically identified as Covered Services in the Schedule of Benefits.

a) Tuberosity Reduction – The process of reshaping of the bone supporting a dental prosthesis.

G. Orthodontics

The following services are not covered under the orthodontic benefit :

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

2. Surgical Orthodontics – Surgical Orthodontics to reposition the jaw bones and teeth is not covered.

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

4. Orthognathic Surgery- Surgery to move the jaw bones into alignment is not covered.

5. 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 are 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.

10. Lost, Stolen, Damaged or Broken Appliances - Damaged or lost retainers, brackets, bands, wires or other materials supplied by the orthodontist are not covered.

11. Extractions for Orthodontic Purposes - Extractions are covered only when they can be performed at a Western Dental Center office, at the discretion of the Western Dental Center office dentist.

H. General Exclusions

The following general exclusions are applicable to all services:

1. Treatment by someone other than a Participating Provider and/or duly qualified technician under the direction of a Participating Provider except for Emergency treatment as provided in Section VIII., or upon prior authorization by the Plan.
2. Charges for medical treatment, prescriptions, or other non-dental charges incurred.
3. Hospitalization costs for any dental procedure, including all hospital services and medications, will be borne by the Member. When deemed medically necessary by the Member's physician and preauthorized by the Plan, otherwise covered dental services that are delivered in an inpatient or outpatient hospital setting are Covered Services under the Benefit Plan. See attached Schedule of Benefits for applicable Copayments. All other associated expenses, including any applicable copayment for general anesthesia and IV conscious sedation, remain the responsibility of the Member.

4. Treatment of malignancies, neoplasms, and cysts.
5. Treatment of disturbances of the Temporomandibular Joint (T.M.J.).
6. Procedures, restorations, and appliances to correct congenital or developmental malformations.
7. Services and supplies which are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice are not covered.
8. Dental expenses incurred in connection with any dental procedure started after termination of coverage.
9. Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage are excluded.
10. Appliances to correct and control harmful habits are not covered (e.g. tongue thrust and thumb sucking), unless specified in the accompanying Schedule of Benefits (See attached Schedule of Benefits for detailed information.). This exclusion is not intended to eliminate coverage for dental services based on the cause of the underlying condition being treated.

XI. 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 who 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.

H. WORKERS' COMPENSATION - Should any benefit or service rendered result from a Workers' Compensation Injury Claim, the Member shall assign his/her right to reimbursement from other sources to the Plan or to the Participating Provider who rendered the service.

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 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.

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.

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 Member Services 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 Member Services 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 Member Services 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 Member Services 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.

SECOND DENTAL OPINIONS

A Member or a Participating Provider may request a second opinion consultation by writing or calling the Plan's Member Services Department at (800) 992-3366. Decisions and notifications regarding requests for second opinion consultations will be rendered within the following time limits: For routine second opinion requests, the decision to approve or deny requests for second opinion consultations will be made within 5 business days of the Plan's receipt of the request. For

urgent requests, the second opinion will be authorized or denied within 72 hours of the Plan's receipt of the request. The requesting Participating Provider will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to a requesting Member verbally (when possible) and in writing within 2 business days.

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

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

XIII. FACILITIES

Members may obtain a list of the Plan's Participating Providers by calling the Member Services Department. Participating Providers are open during normal business hours as specified in the Participating Provider listing. Should a Member have a question regarding the days and/or hours of the Participating

Provider's facility, he/she may reference the Provider listing or may write or call either the Participating Provider at the address and telephone number specified on the Provider list or the Plan at the address and telephone number listed in this Evidence of Coverage Booklet. A copy of the Provider Listing is also included in the Enrollment Package.

A Member may receive Emergency Dental Services after regularly scheduled office hours by calling the local telephone number for the Participating Provider's facility. The Member will be charged the applicable Copayment as specified in the Schedule of Benefits for "Office Visit - After Regular Scheduled Hours (ADA procedure code 9940)."

XIV. PREPAYMENT FEES

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.

XV. 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.

XVI. 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.

XVII. 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 XXII 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 V.I., Orthodontics.

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.

XVIII. 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

XIX. 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.

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

XX. 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.

XXI. 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 eligibility and will be subject to change; however, the premium charged to you will not exceed 102% of the premium charged for active employees and/or Dependents in a comparable status. The continuation coverage will be the same as the coverage available to continuing employees, regardless of 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.

XXII. CAL-COBRA INFORMATION

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 otherwise end, which must be offered by employers of twenty (20) or more persons.

Eligibility and Qualifying Events: The Member has the right to choose Cal-COBRA continuation coverage if any of the Qualifying Events occur, 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 reasons 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 occur 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.

XXIII. 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.

XXIV. ORGAN AND TISSUE DONATION

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.

XXV. SCHEDULE OF BENEFITS

CODE	PROCEDURE	ENROLLEE COPAY
D0100 - D0999 DIAGNOSTIC		
D0120	Periodic oral evaluation	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral radiographs - complete series (including bitewings) - limited to 1 series every 24 months	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0250	Extraoral - first film	No Cost
D0260	Extraoral - each additional film	No Cost
D0270	Bitewing radiograph - single film	No Cost
D0272	Bitewing radiograph - two films	No Cost
D0274	Bitewing radiograph - four films - limited to 1 series every 6 months	No Cost
D0277	Vertical bitewings - 7 to 8 films	No Cost
D0330	Panoramic film	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services)	No Cost
D1000-D1999 PREVENTIVE		
D1110	Prophylaxis cleaning - adult - 1 per 6 month period	No Cost
D1110	Additional Prophylaxis cleaning - adult (within the 6 month period)	$45.00
D1120	Prophylaxis cleaning - child - 1 per 6 month period	No Cost
D1120	Additional Prophylaxis cleaning - child (within the 6 month period)	$35.00
D1201	Topical application of fluoride (including prophylaxis) - child - to age 19; 1 per 6 month period	No Cost
D1201	Additional topical application of fluoride (including prophylaxis) - child - to age 19 (within the 6 month period)	$35.00
D1203	Topical application of fluoride (prophylaxis not included) - child - to age 19; 1 per 6 month period	No Cost
D1204	Topical application of fluoride (prophylaxis not included) - adult - to age 19; 1 per 6 month period	No Cost
D1205	Topical application of fluoride (including prophylaxis) - adult - 1 per 6 month period	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - limited to permanent molars through age 15	No Cost
D1510	Space maintainer - fixed - unilateral	No Cost
D1515	Space maintainer - fixed - bilateral	No Cost

CODE	PROCEDURE	ENROLLEE COPAY

D0100 - D0999 DIAGNOSTIC (continued)

D1520	Space maintainer - removable - unilateral	No Cost
D1525	Space maintainer - removable - bilateral	No Cost
D1550	Re-cementation of space maintainer	No Cost

D2000-D2999 RESTORATIVE

(a)Member will pay an additional copayment of $150.00 for placement of porcelain on a molar tooth. (b)Base metal is the benefit. Noble or High noble (precious) metal, if elected, will be charged to the Member at the additional maximum cost to the Member of $100.00 per tooth for noble metal or $125.00 per tooth for high noble (precious) metal. If a cast post and core is made of noble or high noble (precious) metal, an additional fee up to $100.00 per tooth for noble metal or up to $125.00 per tooth for high noble (precious) metal will be charged for the upgrade.)

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	$75.00
D2392	Resin-based composite - two surfaces, posterior	$90.00
D2393	Resin-based composite - three surfaces, posterior	$105.00
D2394	Resin-based composite - four or more surfaces, posterior	$125.00
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - one surface	No Cost
D2543	Onlay - metallic - two surfaces	No Cost
D2544	Onlay - metallic - three or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface (a)	No Cost
D2620	Inlay - porcelain/ceramic - two surfaces (a)	No Cost
D2630	Inlay - porcelain/ceramic - three or more surfaces (a)	No Cost
D2642	Onlay - porcelain/ceramic - one surface (a)	No Cost
D2643	Onlay - porcelain/ceramic - two surfaces (a)	No Cost
D2644	Onlay - porcelain/ceramic - three or more surfaces (a)	No Cost
D2650	Inlay - resin-based composite - one surface (a)	No Cost
D2651	Inlay - resin-based composite - two surfaces (a)	No Cost
D2652	Inlay - resin-based composite - three or more surfaces (a)	No Cost
D2662	Onlay - resin-based composite - one surface (a)	No Cost
D2663	Onlay - resin-based composite - two surfaces (a)	No Cost
D2664	Onlay - resin-based composite - three or more surfaces (a)	No Cost
D2710	Crown - resin-based composite (indirect) (a)	No Cost
D2712	Crown - 3/4 resin-based composite (indirect) (a)	No Cost
D2720	Crown - resin with high noble metal (a,b)	No Cost
D2721	Crown - resin with predominantly base metal (a)	No Cost
D2722	Crown - resin with noble metal (a,b)	No Cost
D2740	Crown - porcelain/ceramic substrate (a)	No Cost
D2750	Crown - porcelain fused to high noble metal (a,b)	No Cost
D2751	Crown - porcelain fused to predominantly base metal (a)	No Cost
D2752	Crown - porcelain fused to noble metal (a,b)	No Cost
D2780	Crown - 3/4 cast high noble metal (b)	No Cost
D2781	Crown - 3/4 cast predominantly base metal	No Cost
D2782	Crown - 3/4 cast noble metal (b)	No Cost
D2783	Crown - 3/4 porcelain/ceramic (a)	No Cost
D2790	Crown - full cast high noble metal (b)	No Cost
D2791	Crown - full cast predominantly base metal	No Cost
D2792	Crown - full cast noble metal (b)	No Cost
D2910	Recement inlay, onlay or partial coverage restoration	No Cost
D2915	Recement cast or prefabricated post and core	No Cost

CODE	PROCEDURE	ENROLLEE COPAY

D2000 - D2999 RESTORATIVE (continued)

D2920	Recement crown	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2940	Sedative filling	No Cost
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Cast post and core in addition to crown - includes canal preparation (b)	No Cost
D2953	Each additional cast post - same tooth - includes canal preparation (b)	No Cost
D2954	Prefabricated post and core in addition to crown - base metal post; includes canal preparation	No Cost
D2957	Each additional prefabricated post - same tooth - base metal post; includes canal preparation	No Cost

D3000-D3999 ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	Root canal - anterior (excluding final restoration)	No Cost
D3320	Root canal - bicuspid (excluding final restoration)	No Cost
D3330	Root canal - molar (excluding final restoration)	No Cost
D3346	Retreatment of previous root canal therapy - anterior	No Cost
D3347	Retreatment of previous root canal therapy - bicuspid	No Cost
D3348	Retreatment of previous root canal therapy - molar	No Cost
D3351	Apexification/recalcification - Initial visit (apical closure/calcific repair of perforations, root resorption, etc....)	No Cost
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc....)	No Cost
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc...)	No Cost
D3410	Apicoectomy/periradicular surgery - anterior	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	No Cost
D3425	Apicoectomy/periradicular surgery - molar (first root)	No Cost
D3426	Apicoectomy/periradicular surgery - (each additional root)	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation, per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost

D4000-D4999 PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	No Cost

CODE	PROCEDURE	ENROLLEE COPAY

D4000-D4999 PERIODONTICS (continued)

D4341	Periodontal scaling and root planing - four or more teeth per quadrant - limited to 4 quadrants during any 12 consecutive months	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - limited to 4 quadrants during any 12 consecutive months	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - limited to 1 treatment in any 12 consecutive months	No Cost

D5000-D5899 PROSTHODONTICS . . . . . .

D5110	Complete denture - maxillary	No Cost
D5120	Complete denture - mandibular	No Cost
D5130	Immediate denture - maxillary	No Cost
D5140	Immediate denture - mandibular	No Cost
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	No Cost
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	No Cost
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	No Cost
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	No Cost
D5281	Removable unilateral partial denture - one piece cast metal including clasps and teeth	No Cost
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5510	Repair broken complete denture base	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth)	No Cost
D5610	Repair resin denture base	No Cost
D5620	Repair cast framework	No Cost
D5630	Repair or replace broken clasp	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture	No Cost
D5710	Rebase complete maxillary denture	No Cost
D5711	Rebase complete mandibular denture	No Cost
D5720	Rebase partial maxillary denture	No Cost
D5721	Rebase partial mandibular denture	No Cost
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline partial maxillary denture (chairside)	No Cost
D5741	Reline partial mandibular denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	No Cost
D5751	Reline complete mandibular denture (laboratory)	No Cost
D5760	Reline partial maxillary denture (laboratory)	No Cost
D5761	Reline partial mandibular denture (laboratory)	No Cost
D5820	Interim partial denture (maxillary) - limited to 1 in any 12 consecutive months	No Cost
D5821	Interim partial denture (mandibular) - limited to 1 in any 12 consecutive months	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

CODE	PROCEDURE	ENROLLEE COPAY

D6200-D6999 PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

(a)Member will pay an additional copayment of $150.00 for placement of porcelain on a molar tooth. (b)Base metal is the benefit. Noble or High noble (precious) metal, if elected, will be charged to the Member at the additional maximum cost to the Member of $100.00 per tooth for noble metal or $125.00 per tooth for high noble (precious) metal. If a cast post and core is made of noble or high noble (precious) metal, an additional fee up to $100.00 per tooth for noble metal or up to $125.00 per tooth for high noble (precious) metal will be charged for the upgrade.)

D6210	Pontic - cast high noble metal (b)	No Cost
D6211	Pontic - cast predominantly base metal	No Cost
D6212	Pontic - cast noble metal (b)	No Cost
D6240	Pontic - porcelain fused to high noble metal (a,b)	No Cost
D6241	Pontic - porcelain fused to predominantly base metal (a)	No Cost
D6242	Pontic - porcelain fused to noble metal (a,b)	No Cost
D6245	Pontic - porcelain/ceramic (a)	No Cost
D6250	Pontic - resin with high noble metal (a,b)	No Cost
D6251	Pontic - resin with predominantly base metal (a)	No Cost
D6252	Pontic - resin with noble metal (a,b)	No Cost
D6600	Inlay - porcelain/ceramic, two surfaces (a)	No Cost
D6601	Inlay - porcelain/ceramic, three or more surfaces (a)	No Cost
D6602	Inlay - cast high noble metal, two surfaces (b)	No Cost
D6603	Inlay - cast high noble metal, three or more surfaces (b)	No Cost
D6604	Inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Inlay - cast noble metal, two surfaces (b)	No Cost
D6607	Inlay - cast noble metal, three or more surfaces (b)	No Cost
D6608	Onlay - porcelain/ceramic, two surfaces (a)	No Cost
D6609	Onlay - porcelain/ceramic, three or more surfaces (a)	No Cost
D6610	Onlay - cast high noble metal, two surfaces (b)	No Cost
D6611	Onlay - cast high noble metal, three or more surfaces (b)	No Cost
D6612	Onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Onlay - cast noble metal, two surfaces (b)	No Cost
D6615	Onlay - cast noble metal, three or more surfaces (b)	No Cost
D6720	Crown - resin with high noble metal (a,b)	No Cost
D6721	Crown - resin with predominantly base metal (a)	No Cost
D6722	Crown - resin with noble metal (a,b)	No Cost
D6740	Crown - porcelain/ceramic (a)	No Cost
D6750	Crown - porcelain fused to high noble metal (a,b)	No Cost
D6751	Crown - porcelain fused to predominantly base metal (a)	No Cost
D6752	Crown - porcelain fused to noble metal (a,b)	No Cost
D6780	Crown - 3/4 cast high noble metal (b)	No Cost
D6781	Crown - 3/4 cast predominantly base metal	No Cost
D6782	Crown - 3/4 cast noble metal (b)	No Cost
D6783	Crown - 3/4 porcelain/ceramic (a)	No Cost
D6790	Crown - full cast high noble metal (b)	No Cost
D6791	Crown - full cast predominantly base metal	No Cost
D6792	Crown - full cast noble metal (b)	No Cost
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6970	Cast post and core in addition to fixed partial denture retainer - includes canal preparation (b)	No Cost
D6971	Cast post as part of fixed partial denture retainer - includes canal preparation (b)	No Cost
D6972	Prefabricated post and core in addition to fixed partial denture repair - base metal post; includes canal preparation	No Cost
D6973	"Core buildup for retainer, including any pins	No Cost

CODE	PROCEDURE	ENROLLEE COPAY

D6200-D6999 PROSTHODONTICS, fixed (continued)

D6976	Each additional cast post - same tooth - includes canal preparation (b)	No Cost
D6977	Each additional prefabricated post - same tooth - base metal post; includes canal preparation	No Cost
D6980	Fixed partial denture repair, by report	No Cost

D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY

D7111	Extraction, coronal remnants - deciduous teeth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	No Cost
D7240	Removal of impacted tooth - completely bony	No Cost
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	No Cost
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7285	Biopsy of oral tissue - hard (bone, tooth)	No Cost
D7286	Biopsy of oral tissue - soft - does not include pathology laboratory procedures	No Cost
D7310	Alveoloplasty in conjunction with extractions - per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth	No Cost
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth	No Cost
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	No Cost
D7471	Removal of lateral esostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	No Cost
D7520	Incision and drainage of abscess - extraoral soft tissue	No Cost
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	No Cost
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 ORTHODONTICS

The benefit for pre-treatment records and diagnostic services includes:		$150.00
D0210	Intraoral - complete series (including bitewings)	
D0322	Tomographic survey	
D0330	Panoramic film	
D0340	Cephalometric film	
D0350	Oral/facial photographic images	
D0470	Diagnostic casts	
The benefit for post-treatment records includes:		$120.00
D0210	Intraoral - complete series (including bitewings)	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$500.00
D8020	Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19	$500.00
D8030	Limited orthodontic treatment of the adolescent dentition - adolescent to age 19	$500.00

CODE	PROCEDURE	ENROLLEE COPAY

D8000-D8999 ORTHODONTICS (continued)

D8040	Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children	$500.00
D8050	Interceptive orthodontic treatment of the primary dentition	$500.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$500.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19	$1,000.00
D8080	Comprehensive orthodontic treatment of the transitional dentition - adolescent to age 19	$1,000.00
D8090	Comprehensive orthodontic treatment of the transitional dentition - adults, including covered dependent adult children	$1,000.00
D8660	Pre-orthodontic treatment visit	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers)	$250.00
D8999	Unspecified orthodontic procedure, by report - includes treatment planning session	No Cost

D9000-D9999 ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia	No Cost
D9220	Deep sedation/general anesthesia - first 30 minutes (when medically necessary)	No Cost
D9221	Deep sedation/general anesthesia - each additional 15 minutes (when medically necessary)	No Cost
D9220	Deep sedation/general anesthesia - first 30 minutes	$165.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$80.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$165.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$80.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	No Cost
D9430	Office visit for observation (during regularly scheduled hours)- no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	No Cost
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9972	External bleaching - per arch - limited to one bleaching tray and gel for two weeks of self treatment	$125.00
D9999	Unspecified adjunctive procedure, by report - includes failed appointment without 24 hour notice	$10.00

If Services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be preauthorized by Western Dental Plan. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" means the Contract Dentist's fees on file with Western Dental. Questions regarding these fees should be directed to the Member Services Department at (800)992-3366.

Notes:

(a) = Enrollee pays additional copayment of $150.00 for placement on a molar tooth.

(b) = Enrollee pays additional copayment for lab cost of $100.00 for noble metal and $125 for high noble metal.

NOTES