This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. Your employer will provide you with a copy of the health plan contract upon request.
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YOUR DENTAL BENEFITS

BASIC FACTS

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

We agree to furnish to you the plan of dental benefits explained in this Evidence of Coverage Form and any amendments thereto, subject to the terms and conditions of the agreement issued to the group. These benefits are available to you provided that services are rendered or authorized by your participating dentist, your participating dental office or us.

WHAT IS DENTAL NET?

Dental Net is a statewide dental program. The program consists of a network of participating dental offices and dental professionals who have contracted with us to provide you with the wide range of dental services for which you are covered under this plan. From these many providers, you choose the participating dental office that will provide your dental care.

YOUR ID CARD

Your key to Dental Net is your identification card. Be sure to keep this card with you and to present it whenever you are requested to do so.

CHOOSING A DENTAL OFFICE AND DENTIST

Upon enrollment, each member is asked to choose a Dental Net participating dental office. Each member is allowed to choose his/her own participating dentist. Your participating dentist will diagnose and treat most of your dental conditions and will coordinate all your dental care – referring you to specialists when necessary. We urge you to develop a close relationship with your participating dentist and to follow his or her advice carefully.
CHANGING PARTICIPATING DENTAL OFFICES

Requests by the Member. You may transfer from one participating dental office to another. To do this, you must call us toll free at 1-800-627-0004, or write us, by the 15th of the month. Most requests will be effective on the first of the month following our receipt of notification. We must approve your request for the transfer to become effective. If you or your family members have dental work in progress, you cannot switch to another participating dental office until the work is completed.

Request by the Participating Dental Office. If a participating dental office requests a member’s enrollment to be transferred, it will be considered based upon the nature of the request. If the request is due to a member’s abusive language, behavior or lack of cooperation displayed in the dental office, we may notify the group of the incident and request the member’s Dental Net coverage to be terminated from the group’s agreement with us, as indicated under the section WHO’S COVERED AND WHEN: WHEN YOUR COVERAGE ENDS.

HOW TO OBTAIN CARE

The procedures you follow to obtain care depend on the type of care you need: General Care, Specialty Referral Care or Emergency Care. In reading over these procedures below, you will notice one important rule: we (your participating dentist, your participating dental office and us) are responsible for authorizing all the care you receive. If we do not authorize your care, benefits will not be payable under this plan. If you are ever in doubt, contact your participating dental office or us.

GENERAL CARE

Your participating dentist is the first person you should consult for dental care. He or she is responsible for providing you with dental care and determining when you need Specialty Referral Care.

To make an appointment with your participating dentist, call your participating dental office. (Please call in advance, especially if specific days or times are desired.) When you call, please identify yourself as a Dental Net member and have the following information from your identification card available:

- Your name
- The certificate number on your ID card
- The group number from your ID card
The name of your participating dentist (If you have not selected a dentist, call us toll free at 1-800-627-0004.)

A brief explanation of your symptoms, if any

Your participating dental office will then schedule an appointment for you or otherwise arrange for appropriate care.

When you come in for your appointment, you will be asked to show your identification card. Since you must have this card to receive your Dental Net benefits, be sure to have it with you.

Upon your first visit to your participating dental office, it is most common to expect an examination, x-rays and treatment evaluation only. Subsequent appointments for follow-up treatment are scheduled based upon this evaluation and those procedures requiring more immediate attention.

If you need to cancel or reschedule an appointment, please notify your participating dental office as far in advance as possible. This courtesy may allow your participating dental office to accommodate another person in need of dental treatment. Your participating dental office may charge for a broken appointment or failure to cancel if you have not provided at least 24 hours notice. These charges are your responsibility and are NOT reimbursable by us.

Second Opinions. If you have a question about your dental condition or about a plan of treatment recommended by your participating dentist or a participating specialist to whom you were referred, you may receive a second dental opinion. You must request a second opinion through the Dental Net Member Services Department. The second opinion will consist of a consultation only. No other services or procedures are included. When you request a second dental opinion you will receive a decision promptly. If you have a serious dental condition, a decision will be made within 72 hours whenever possible. If your request is approved, the second opinion will be provided by another dentist or specialist of your choice who contracts with Dental Net. If your request is denied, you may appeal the denial through our grievance procedures (see GRIEVANCE PROCEDURES). Your grievance will be reviewed by a dentist with an appropriate clinical background.
SPECIALTY REFERRAL CARE

Your participating dental office is responsible for providing all covered services, subject to any applicable member co-payments, as listed in the sections WHAT’S COVERED and SCHEDULE OF CO-PAYMENTS. However, certain dental services may be eligible for referral to a participating specialist. If your participating dentist determines that specialty care may be needed, he or she will submit a request for authorization for specialty referral to us.

If the request is authorized, we will send notification to you indicating the following:

- The services that have been authorized
- The participating specialty office that will provide care and their telephone number
- The time limitation that you have to receive the services authorized
- Any co-payments you will be required to pay that may apply to the services

Referrals for specialty care are made at the sole and absolute discretion of your participating dental office and us. Additionally, the participating specialty office designated to provide specialty referral care is chosen at our sole and absolute discretion.

When you receive the authorization, you should contact the participating specialty office to arrange for an appointment. The specialty office will schedule a consultation appointment.

After the evaluation and consultation of the services to be performed, the specialty office will schedule your next appointment to begin the authorized specialty referral services. In the event there are any changes to the authorized specialty referral services suggested by the participating specialty office, there may be a delay while we review the proposed changes for acceptable services determination.

If the request is not authorized because it does not meet the specialty referral guidelines, you will be notified by us.

You should not be billed by the participating specialist for authorized specialty referral services. However, you are responsible for all applicable co-payments which are to be paid to the participating specialist at the time the services are provided.
REMEMBER: ONLY THE SERVICES WHICH ARE REFERRED BY YOUR PARTICIPATING DENTAL OFFICE AND AUTHORIZED BY US ARE TO BE PROVIDED BY THE REFERRAL SPECIALIST. ANY SERVICES WHICH ARE PROVIDED WITHOUT REFERRAL FROM YOUR PARTICIPATING DENTAL OFFICE AND AUTHORIZATION BY US WILL NOT BE COVERED UNDER THIS PLAN AND WILL BE YOUR FINANCIAL RESPONSIBILITY.

EMERGENCY CARE

Emergency services are dental services provided for the initial treatment for alleviation of severe pain or bleeding and/or swelling. Emergency services are not for continuing any treatment plan currently in process, unless it has been authorized. While it is intended that all services, including emergency services, are to be provided by your participating dental office, we recognize that special circumstances may exist which prevent you from receiving emergency dental treatment from your participating dental office. This plan provides benefits for two different types of emergency services situations which are described below. You are responsible for any applicable co-payments regardless of who provided the emergency services.

Outside the Enrollment Area. If you are temporarily more than 35 miles from your participating dental office and you need emergency dental care, you may obtain care from any dentist. You will have to pay for such emergency services; however, upon submission of an itemized paid receipt of the emergency services rendered, we will reimburse you up to a maximum of $50, less any applicable co-payments for the procedures performed. If you present an itemized statement from a dental office which is located within 35 miles of your participating dental office, you will NOT be reimbursed for that expense.

Within the Enrollment Area. If you are within the enrollment area of your participating dental office, you must obtain care from that office.

WHAT’S COVERED

The wide range of dental benefits available to you under this plan are listed in detail in the SCHEDULE OF CO-PAYMENTS. What follows is a brief description of how the benefits of this plan work.

COORDINATION OF BENEFITS

The benefits of this plan are subject to coordination of benefits under certain other plans. For a detailed explanation, please see the section titled COORDINATION OF BENEFITS.
CO-PAYMENTS

Some services are provided to you free of co-payments. For certain other services, you are required to pay a co-payment amount at the time the services are provided. These co-payments are specified in the SCHEDULE OF CO-PAYMENTS.

TYPES OF SERVICE

The following is a brief overview of the dental services available to you under this plan. For a more detailed listing, refer to the SCHEDULE OF CO-PAYMENTS.

Diagnostic. Diagnostic services are routine services to determine the type of treatment you may need.

Preventive. Preventive services are performed to help prevent certain conditions from occurring.

Restorative. Restorative services are performed to restore tooth structure lost as a result of dental decay.

Endodontics. Endodontic services are performed to treat diseases of the tooth pulp nerve and associated structures.

Periodontics. Periodontic services are performed to treat diseases of the gums and supporting structures.

Removable Prosthodontics. Removable prosthodontic services are performed to replace missing teeth with full or partial dentures.

Fixed Prosthodontics. Fixed prosthodontic services are performed to repair tooth structure lost due to dental decay or replace missing teeth with bridges.

Oral Surgery. Oral surgery is performed when you require surgical procedures involving the teeth, bone and gums associated with the teeth.

WHEN DENTAL PROCEDURES START

A dental procedure is considered started when the actual performance of the procedure starts, except that:

- For fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are prepared; or
- For crowns, inlay or onlay, it starts on the first date of preparation of the tooth involved; or
• For root canal therapy, it starts when the pulp chamber of the tooth is opened.

WHAT'S NOT COVERED AND LIMITED SERVICES

The services provided under this plan are all subject to the exclusions and limitations listed below. (The titles given to the exclusions and limitations are for ease of reference; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

LIMITED SERVICES

Denture Relines. Complete and/or partial denture relines or rebases are limited to one per denture during any 12-month period.

Impactions. Removal of impacted teeth is limited to impactions which show radiographic evidence of a pathologic condition or for which the member experiences unresolved symptoms of infection, swelling or chronic pain.

Pediatric Annual Maximum. Pediatric dental services are limited to $500 per calendar year for each child. Referral to a pedodontist will be considered for children to the age of 5. Charges in excess of $500 will be your financial responsibility.

Periodontal Procedures. Periodontal scaling and root planing and/or gingival curettage are limited to one course of therapy per quadrant during any 12-month period. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis is limited to one course of treatment per lifetime.

Precious Metals. The use of alloys with 25% or more noble metal content for any restorative procedure is considered optional and, if used, the additional cost for such alloy should not exceed $100 and will be your responsibility.

Professionally Acceptable Treatment. In cases where multiple acceptable methods of treatment exist, the least expensive professionally acceptable treatment is considered the covered benefit.

Prophylaxis. Procedures are limited to two treatments per calendar year. If a third prophylaxis is provided within the calendar year, it will be subject to an 80% co-payment based on the participating dentist's usual fee.

Sealants. Sealants are limited to children under 16 years of age for permanent molars, unrestored. Treatment is limited to once every 36 months per tooth.
Prosthodontic Replacements:

1. Partial dentures are not eligible for replacement within five years of original placement unless required as a result of additional tooth loss that cannot be restored by modification of the existing partial denture.

2. Crowns, bridges, inlays and/or complete dentures are not eligible for replacement within five years of original placement.

Oral Exams. Oral exams are limited to two per calendar year.

Porcelain on molars. If porcelain to metal crowns are placed on molars, an additional charge of $75.00 per tooth will be charged.

Seven (7) or more crowns. If a treatment plan involves seven (7) or more crowns and/or fixed bridge units, an additional charge of $125.00 per tooth or artificial tooth will be charged for all teeth and artificial teeth.

Unauthorized Services. Dental services must be received from your participating dental office unless an exception is specifically authorized in writing by your participating dental office or by us.

SERVICES NOT COVERED

Acts of Third Parties. Under some circumstances, a member may need services under this plan for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party for an injury, disease or other condition. In that event, any benefits we pay under this plan for such covered services will be subject to the following:

1. We and your participating dental office will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party’s insurer, or the third party’s guarantor. The lien will be in an amount equal to the reasonable cash value of the benefits provided by your participating dental office and us under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable, but, not more than the amount allowed by California Civil Code Section 3040.
2. You must advise your participating dental office and us in writing within 60 days of filing a claim against the third party, and take necessary action, furnish such information and assistance, and execute such papers as your participating dental office and we may require to facilitate enforcement of our rights. You must not take action which may prejudice the rights or interest of your participating dental office and us under this plan. Failure to give such notice to, or cooperate with, your participating dental office and us, or actions that prejudice the rights or interests of your participating dental office and us will be a material breach of this plan and will result in your being personally responsible for reimbursing your participating dental office and us.

3. We or your participating dental office will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

**Congenital (Hereditary) or Developmental Malformations.** Dental treatment or expenses incurred in connection with the correction of congenital or developmental malformations including but not limited to enamel hypoplasia, fluorosis, anodontia, supernumerary or impacted teeth other than third molars.

**Cosmetic Services.** Dental services necessary solely for cosmetic reasons including, but not limited to, bleaching of non-vital discolored teeth, veneers and all other cosmetic procedures (unless specifically shown as a covered benefit).

**Cysts and Neoplasms.** Histopathological exams, and/or the removal of tumors, cysts, neoplasms, and foreign bodies.

**Experimental or Investigative Procedures.** Procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the organized dental community.

**Extensive Oral Rehabilitation.** Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive oral rehabilitation or reconstruction. (Other than for replacement of structure lost due to dental decay). Five (5) or more crowns subject to our approval.

**Fractures or Dislocations.** Treatment of jaw fractures or dislocations.

**General Anesthesia.** General anesthesia, inhalation sedation, intravenous sedation or intramuscular sedation.
**Government Programs.** Care or treatment which is obtained from, or for which payment is made by, any Federal, State, County, Municipal, or other government agency, including any foreign government.

**Hospital Charges.** Hospital and associated physician charges of any kind or charges for any dental treatment which cannot be performed in the *participating dental office*.

**Implants.** Dental procedures and charges incurred as part of implants or the removal of the same. Fixed or removable prosthetics in conjunction with implants. Prophylaxis on implants.

**Lost or Stolen Dentures or Appliances.** Replacement of lost crowns, lost or stolen dentures, bridgework, or other dental appliances.

**Member Health Limitations.** Charges for any dental treatment, which because of your general health, or mental, emotional, behavioral, or physical limitations, cannot be performed in the *participating dental office*.

**Not Acceptable Services.** Any service or supply which we determine not to be an *acceptable service*. (See DEFINITIONS.)

**Periodontal Splinting.** Dental treatment or expenses incurred in connection with periodontal splinting.

**Procedures Not Specified as Covered.** Any procedure not specifically listed as a *covered service*.

**Prosthetic Services Age Limitations.** Inlays, onlays, crowns, fixed bridges or removable cast partials for *members* under sixteen (16) years of age. Space maintainers for *members* over age sixteen (16).

**Services Provided Before or After the Term of Your Coverage.** Dental treatment or expenses incurred in connection with any dental procedure started prior to your *effective date* or after termination of your coverage, except as specifically stated under EXTENSION OF BENEFITS.

**Surgical Services.** Tooth implantation or transplantation, orthognathic surgery, soft tissue or osseous grafts, hemisection, or root amputation, apexification, vestibuloplasty, or ostectomy procedures.

**Treatment by a Non-Participating Dentist.** Any corrective treatment required as a result of dental services performed by a *non-participating dentist* while this coverage is in effect, and any dental services started by a *non-participating dentist*, will not be our responsibility, nor the responsibility of the *participating dental office*, for completion.
Treatment of the Joint of the Jaw. Diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint) or associated musculature, nerves and other tissues.

Vertical Dimension and Attrition. Dental treatment or procedures (other than those for replacement of structure lost due to dental decay) required in conjunction with opening a bite or replacing tooth structure lost by wear, erosion or abrasion, but not limited to bruxism. (Does not apply to alteration by removable prosthodontics.)

Workers’ Compensation. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any workers’ compensation or occupational disease law, even if you did not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers’ compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in the “Acts of Third Parties” provision set forth in this section.

Drugs or Dispensing of Drugs. Plan does not cover prescription drugs as a dental benefit.

Questionable, Guarded or Poor Prognosis. Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. We will allow for observation or extraction and prosthetic replacement.

Personalization, Characterization or Precision Attachments. Precision attachments, characterization or personalization of dentures is excluded.

Crown Lengthening. Crown exposure, ligation and crown lengthening are not covered.

Removal of Third Molars. Immature erupting third molars are not covered for extraction, i.e., tooth proceeding through a normal eruption process.

Primary Restorations. Gold, porcelain or resin fillings on primary teeth are excluded.

Denture Replacement. Dentures, full or partial-replacements will be made only if existing denture is at least five (5) years old, is unsatisfactory and cannot be made serviceable.
WHO’S COVERED AND WHEN

HOW YOU ENROLL

ELIGIBLE STATUS

1. **Subscribers.** You are in an eligible status if you meet any of the following requirements:

   a. Permanent *full-time employee* who (i) is a member of IBEW Local 18 and (ii) works 20 hours or more a week in the conduct of the business of his/her employer.

   b. Permanent *part-time employee* who (i) is a member of IBEW Local 18 and (ii) works at least 19 hours a week in the conduct of the business of his/her employer.

   c. *Early-retired employee* who is under age 65, retired from active employment, eligible to receive health plan benefits as part of the group’s pension plan and was enrolled in an IBEW Local 18 Anthem Blue Cross Plan at time of retirement.

   d. *Retired employee* who (i) is age 65 or older and was enrolled in an IBEW Local 18 Anthem Blue Cross DHMO or PPO dental plan at time of retirement or (ii) was an early-retired employee who turned 65 and was enrolled in an IBEW Local 18 Anthem Blue Cross DHMO or PPO dental plan prior to turning age 65.

2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *subscriber’s spouse or domestic partner*; and (b) An unmarried *child*.

**Definition of Family Member**

1. **Spouse** is the *subscriber’s spouse* under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

2. **Domestic partner** is the *subscriber’s domestic partner* under a legally registered and valid domestic partnership; or

   For non-registered domestic partners, the following shall apply:
The domestic partner must have lived with the employee for at least 12 months, must be added by the employee or retiree to his or her health and/or dental plan within 31 days of the end of the 12-month period and must meet the following qualifications:

-- Both the employee/retiree and domestic partner must submit a copy of their California Driver’s License or identification card. This is to verify that the addresses match one another and are the same as the employee’s/retiree’s address of record with the Department of Water and power. The Affidavit and application cannot be processed until all addresses are consistent.

-- Both the employee and domestic partner are at least 18 years old.

-- Neither the employee/retiree nor domestic partner was married to anyone during the 12-month qualifying period.

-- The employee/retiree must pay income tax on the amount of the health or dental plan subsidy that will be paid by the Department to provide coverage for the domestic partner and the domestic partner’s eligible dependent children.

-- The employee/retiree must file a confidential affidavit with the DWP Health Plans Administration Office prior to enrolling a domestic partner in an IBEW Local 18 Health Plan.

Domestic partner does not include any person who is: (a) covered as a subscriber; or (b) in active service in the armed forces.

3. **Child** is the subscriber’s, spouse’s or domestic partner’s unmarried natural child, stepchild, legally adopted child, or a child for whom the subscriber, spouse or domestic partner has been appointed legal guardian by a court of law, subject to the following:

   a. The child depends on the subscriber, spouse or domestic partner for financial support or the subscriber, spouse or domestic partner is legally required to provide group health coverage for the child pursuant to an administrative or court order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

   b. A grandchild whose mother is the subscriber’s, spouse’s or domestic partner’s eligible covered minor child. The grandchild must be added within 31 days from date of birth. If you do not have a court order giving you legal guardianship, such child will cease to be eligible on the date the mother is no longer eligible as a family member.
c. The unmarried child is under 19 years of age, or if age 19 or over, that child is eligible until his or her 25th birthday, provided he or she is enrolled as a full-time student in a properly accredited two year community college, four year college or university, or an accredited post-high school trade or technical school. “Full-time student” usually means enrolled for 12 units. Each educational institution will determine the number of units to be considered as full-time students. Any break in the school calendar will not disqualify a child from coverage under this provision. An unmarried child 19 years of age, but, less than 25 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.

d. The unmarried child is 19 years of age, or more and: (i) was covered under the prior plan, or has six or more months of creditable coverage, (ii) is chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the subscriber receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

e. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the subscriber, spouse or domestic partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption.
Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child’s birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the subscriber’s, the spouse’s or domestic partner’s right to control the health care of the child.

f. A child for whom the subscriber, spouse or domestic partner is a legal guardian is considered eligible on the date of the court decree (the “eligibility date”). We must receive legal evidence of the decree.

g. The term "child" does not include any person who is: (i) covered as a subscriber; or (ii) in active service in the armed forces.

h. If both parents are covered as subscribers, their children may be covered as the family members of either, but not of both.

ELIGIBILITY DATE

1. For Subscribers: You become eligible for coverage as follows:

   For active employees - the first day of the month coinciding with or following the date you complete 30 days of continuous, active full-time or part-time employment. (This is your "waiting" period.)

   For early-retired employees - the first of the month following your retirement. (This is your "waiting" period.)

   For retirees 65 or older – the first of the month following your date of retirement. (This is your "waiting" period.)

2. For Family Members: You become eligible for coverage on the later of: (a) the date the subscriber becomes eligible for coverage; or (b) the date you meet the family member definition.

Exceptions to the Waiting Period:

1. If, after you have completed the waiting period, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible on the first day of the month following the date you return.

2. If you were covered under the prior plan, the time you spent under the prior plan will be used to satisfy, or partially satisfy, your waiting period under this plan.
ENROLLMENT

To enroll as a subscriber, or to enroll family members, the subscriber must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the group within 31 days from your eligibility date. We must receive this application from the group within 90 days. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Subject to the timely payment of subscription charges on your behalf, your coverage will begin as follows:

1. Timely Enrollment. If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for subscribers, on your eligibility date; and (b) for family members, on the later of (i) the date the subscriber’s coverage begins, or (ii) the first day of the month after the family member becomes eligible. If you become eligible before the agreement takes effect, coverage begins on the effective date of the agreement.

2. Late Enrollment. If you fail to enroll within 31 days after your eligibility date, you must wait until the group’s next Open Enrollment Period to enroll.

3. Disenrollment. If you voluntarily choose to disenroll from coverage under this plan, you must wait until the group’s next Open Enrollment Period to enroll.

For late enrollees and disenrollees: You may enroll earlier than the group’s next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Special Enrollment Periods

You may enroll without waiting for the group’s next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
   a. You were covered under another dental plan as an individual or dependent, including coverage under a COBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.
b. Your coverage under the other dental plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program’s income or age limits, or you lost no share-of-cost Medi-Cal coverage.

c. You properly file an application with the group within 31 days from the date on which you lose coverage.

2. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your employee dental plan and an application is filed within 31 days from the date the court order is issued.

3. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:

   a. If you are enrolling following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner’s children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective on the first day of the month following the date you file the enrollment application.

   b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse (if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, adoption, or placement for adoption.

OPEN ENROLLMENT PERIOD

The group has an open enrollment period once each year, during the month of May. During that time, an individual who meets the eligibility requirements as a subscriber under this plan may enroll. A subscriber may also enroll any eligible family members at that time. Persons eligible to enroll as family members may enroll only under the subscriber’s plan.
For anyone so enrolling, coverage under this plan will begin on the first day of July. Coverage under the former plan ends when coverage under this plan begins.

WHEN YOUR COVERAGE ENDS

Your coverage under this plan may be canceled without notice from us for any of the reasons explained below. You are not entitled to the benefits of this plan for any services rendered after your coverage has been canceled, even if the services were part of a treatment plan begun before your coverage ended.

SERVICE RELATED EVENTS

We retain the right to cancel your coverage under this plan for any of the reasons listed below:

1. If you fail or refuse to make co-payments at the time the services are provided;
2. If you interfere with the normal operations of the dental office;
3. If you use threatening or aggressive behavior;
4. If you refuse to follow a prescribed course of treatment and the dentist believes that no professionally acceptable alternative exists. If you continue to refuse to follow the prescribed course of treatment, your coverage may be canceled.

NON-SERVICE RELATED EVENTS

Additionally, your coverage under this plan is subject to cancellation without notice from us for any of the reasons listed below. (We do not provide notice of cancellation to individuals but will notify the group.)

1. If the agreement terminates, your coverage ends at the same time. The agreement may be canceled or changed without notice to you.
2. If the group no longer provides coverage for the class of members to which you belong, your coverage ends on the effective date of that change. If the agreement is amended to delete coverage for family members, a family member’s coverage ends on the effective date of that change.
3. Coverage for family members ends when subscriber’s coverage ends.
4. Coverage ends at the end of the period for which subscription charges have been paid to us on your behalf when the required subscription charges for the next period are not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the subscription charge due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

6. If you no longer meet the requirements set forth in the “Eligible Status” provision of HOW YOU ENROLL, your coverage ends as of the subscription charge due date coinciding with or following the date you cease to meet such requirements.

**Exceptions to Item 6:**

a. **Leave of Absence.** If you are a subscriber and the group pays subscription charges to us on your behalf, your coverage may continue for up to six months during a temporary leave of absence approved by the group.

b. **Handicapped Children:** If a child reaches the age limits shown in the "Eligible Status" provision of this section, the child will continue to qualify as a family member if he or she is (i) covered under this plan, (ii) still chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. We will notify the subscriber that the child's coverage will end when the child reaches the plan's upper age limit at least 90-days prior to the date the child reaches that age. The subscriber must send proof of the child's physical or mental condition within 60-days of the date the subscriber receives our request. If we do not complete our determination of the child's continuing eligibility by the date the child reaches the plan's upper age limit, the child will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the child is no longer chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance or a physical or mental condition no longer exists. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

c. **Full time students taking a medical leave of absence from school:** If a child who is 19 years of age or more, enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school), and covered under this plan in accordance with the
“Eligible Status” provision of this section, the child may remain covered under this plan for a period not to exceed 12 months or until the date the child’s coverage would normally end in accordance with the terms and conditions of this plan, whichever comes first, during a medical leave of absence from school. This provision applies if the nature of the child’s health condition does not meet the requirements of the “Handicapped Children” provision, above. The period of coverage during this medical leave of absence will begin on the first day of the leave or on the date a physician determines the child’s illness, injury, or condition prevented the child from attending school, whichever comes first. Any break in the school calendar will not disqualify the child from maintaining coverage under this provision. A physician must certify in writing that the leave of absence from school is medically necessary. This certification must be submitted to us at least 30 days prior to the date the leave begins if the medical reason for the leave and the leave itself are foreseeable. If the medical reason for the leave and the leave itself are not foreseeable, the certification must be submitted to us within 30 days after the date the leave begins.

**Note:** If a marriage or domestic partnership terminates, the subscriber must give or send to the group written notice of the termination. Coverage for a former spouse or domestic partners, and their dependent children, if any, ends according to the “Eligible Status” provisions. If Anthem suffers a loss because of the subscriber failing to notify the group of the termination of their marriage or domestic partnership, Anthem may seek recovery from the subscriber for any actual loss resulting thereby. Failure to provide written notice to the group will not delay or prevent termination of the marriage or domestic partnership.
If the subscriber notifies the group in writing to cancel coverage for a former spouse or domestic partner and the children of the spouse or domestic partner, if any, immediately upon termination of the subscriber’s marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, COVERAGE FOR SURVIVING FAMILY MEMBERS and EXTENSION OF BENEFITS.

Unfair Termination of Coverage. Your coverage may not be terminated because of your health status or requirements for dental care services. If you believe that your coverage has been terminated for either of these reasons, you may request a review of the matter by the Director of the Department of Managed Health Care.
CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the agreement is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a continuation of coverage. Check with your employer for details.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the “Terms of COBRA Continuation” provisions below.

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this agreement as either a subscriber or family member; or (b) a child who is born to or placed for adoption with the subscriber during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any family members acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above. It does not include domestic partners if they are eligible under WHO’S COVERED AND WHEN.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the agreement. The events will be referred to throughout this section by number.

1. For Subscribers and Family Members:
   a. The subscriber’s termination of employment, for any reason other than gross misconduct; or
   b. A reduction in the subscriber’s work hours.

2. For Retired Employees and their Family Members. Cancellation or a substantial reduction of retiree benefits under the plan due to the group’s filing for Chapter 11 bankruptcy, provided that:
   a. The agreement expressly includes coverage for retirees; and
b. Such cancellation or reduction of benefits occurs within one year before or after the group’s filing for bankruptcy.

3. **For Family Members:**
   a. The death of the subscriber;
   b. The spouse’s divorce or legal separation from the subscriber;
   c. The end of a child’s status as a dependent child, as defined by the agreement; or
   d. The subscriber’s entitlement to Medicare.

**ELIGIBILITY FOR COBRA CONTINUATION**

A subscriber or family member, other than a domestic partner, and a child of a domestic partner, may choose to continue coverage under the agreement if your coverage would otherwise end due to a Qualifying Event.

**TERMS OF COBRA CONTINUATION**

**Notice.** The group or its administrator (we are not the administrator) will notify either the subscriber or family member of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the group or its administrator will notify the subscriber of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(d) above, a family member will be notified of the COBRA continuation right.
3. You must inform the group within 60 days of Qualifying Events 3(b) or 3(c) above if you wish to continue coverage. The group in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the group within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all members within a family, or only for selected members.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial subscription charge, must be delivered to us by the group within 45 days after you elect COBRA continuation coverage.
**Additional Family Members.** A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the COBRA continuation period.

**Cost of Coverage.** The *group* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "subscription charge", must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the subscription charge each month from the *group* in order to maintain the coverage in force.

Besides applying to the *subscriber*, the *subscriber’s* rate also applies to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber*;

2. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the subscription charge will be the two-party or three-party rate depending on the number of *children* enrolled); and

3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

**Subsequent Qualifying Events.** Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, a *member*, who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *subscriber’s* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the plan, the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

**When COBRA Continuation Coverage Begins.** When COBRA continuation coverage is elected during the Initial Enrollment Period and the subscription charge is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For *family members* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *agreement*. 
**When the COBRA Continuation Ends.** This COBRA continuation will end on the earliest of:

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*

2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the subscriber, divorce or legal separation, or the end of dependent child status;*

3. The end of 36 months from the date the subscriber became entitled to Medicare, if the Qualifying Event was the subscriber's entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the subscriber will end 36 months from the date the subscriber became entitled to Medicare;

4. The date the agreement terminates;

5. The end of the period for which subscription charges are last paid;

6. The date, following the election of COBRA, the member first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the member, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

7. The date, following the election of COBRA, the member first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a member whose COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

Subject to the agreement remaining in effect, a retired subscriber whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered family members may continue coverage for 36 months after the subscriber's death. But coverage could terminate prior to such time for either the subscriber or family member in accordance with items 4, 5 or 6 above.

If continuation coverage ends due to items 2 or 7 above, a surviving spouse and family members are eligible for the coverage specified in this plan under COVERAGE FOR SURVIVING FAMILY MEMBERS.
EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered members may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled member must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The member must furnish the group with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

Cost of Coverage. For the 19th through 29th months that the total disability continues, the group must remit the cost for the extended continuation coverage to us. This cost (called the "subscription charge") shall be subject to the following conditions:

1. If the disabled member continues coverage during this extension, this charge shall be 150% of the applicable rate for the length of time the disabled member remains covered, depending upon the number of covered dependents. If the disabled member does not continue coverage during this extension, this charge shall remain at 102% of the applicable rate.
2. The cost for extended continuation coverage must be remitted to us by the group each month during the period of extended continuation coverage. We must receive timely payment of the subscription charge each month from the group in order to maintain the extended continuation coverage in force.
3. The group may require that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The subscription charge shall then be 150% of the applicable rate for the 19th through 36th months if the disabled member remains covered. The charge will be 102% of the applicable rate for any periods of time the disabled member is not covered following the 18th month.

**When The Extension Ends.** This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

2. The end of 29 months from the Qualifying Event;

3. The date the agreement terminates;

4. The end of the period for which subscription charges are last paid;

5. The date, following the election of COBRA, the member first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the member, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

6. The date, following the election of COBRA, the member first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the group within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.
SENIOR COBRA CONTINUATION FOR QUALIFYING MEMBERS

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of subscription charges as stated in the agreement, coverage under this plan may be continued for the subscriber, the subscriber’s spouse, and the subscriber’s former spouse (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE shown above (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272).

For the purposes of this section, “former spouse” means: (a) an individual who is divorced from the subscriber; or (b) an individual who was married to the subscriber at the time of the subscriber’s death.

Requirements. The subscriber and spouse may continue coverage under this plan if:

1. The subscriber, or the subscriber on behalf of himself or herself and the spouse, was entitled to, and had elected to continue coverage under, COBRA, as described in the preceding section;
2. The subscriber or spouse has not elected to continue coverage under any other available continuation;
3. The subscriber has worked for the employer for at least the prior five years; and
4. The subscriber is at least 60 years old on the date employment with the employer ended.

The former spouse may continue coverage under this plan in accordance with this section if he or she was covered as a qualified beneficiary under COBRA, as described in the preceding section.

Notice and Election. The employer will notify the subscriber or spouse and the former spouse of the right to continue coverage within 180 days prior to the date continuation of coverage under COBRA is scheduled to end.

For the subscriber and spouse, this continuation may be chosen for both, for the subscriber only, or for the spouse only. The former spouse may elect this continuation for himself or herself only.
To elect this continuation, you must notify us in writing within 30 days prior to the date continuation coverage under COBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. You must remit the initial subscription charge to us within 45 days after you elect this continuation.

**Cost of Coverage.** You are required to pay the entire cost of this continuation coverage. You must remit this cost to us each month during the continuation period. We must receive payment of the subscription charge each month in order to continue the coverage in force. The rate for continuation coverage under this section shall be 213% of the applicable *group* rate. For the purpose of determining subscription charges payable, the *spouse* former spouse continuing coverage alone will be considered to be a *subscriber*.

**Payment Dates.** The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. We will bill you for any retroactive charges which may be due. Succeeding subscription charges are due on the first day of each following month (the Subscription Charge Due Date).

**Grace Period.** For every Subscription Charge Due Date, except the first, there is a 31-day grace period in which to pay subscription charges. If subscription charges are not received by the end of the grace period, your coverage will be canceled at the end of the period for which subscription charges are last paid.

**Change of Subscription Charge.** The amounts of the subscription charges may be changed by us as of any Subscription Charge Due Date. We will provide you with written notice at least 30 days prior to the date any subscription charge increase goes into effect.

**Accuracy of Information.** You are responsible for supplying accurate, up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide. We can hold you responsible for any loss or expense we incur because of your failure to do so.

**When Continuation Ends.** This continuation will end on the earliest of:

1. The end of the period for which subscription charges are last paid;
2. The date the *agreement* terminates;
3. The date, following the election of Senior COBRA, the *subscriber*, *spouse*, or former *spouse* first becomes covered under any group health plan not maintained by the employer;
4. The date, following the election of Senior COBRA, the subscriber, spouse, or former spouse first becomes entitled to Medicare;

5. The date the subscriber, spouse, or former spouse reaches age 65; or

6. For the spouse or former spouse, five years from the date the spouse’s or former spouse’s COBRA continuation coverage ended.

**COVERAGE FOR SURVIVING FAMILY MEMBERS**

If the subscriber dies while covered under this plan, coverage continues for enrolled family members until one of the following occurs:

1. The surviving spouse remarries;
2. Subscription charges are not paid to us on the member’s behalf;
3. The group cancels coverage for the class of subscribers to which the members belongs;
4. The agreement between the group and us terminates; or
5. The child no longer meets all of the conditions of coverage in HOW COVERAGE BEGINS AND ENDS.

**Note:** The cost of continuing coverage under this provision may be more than the cost of coverage the group provides to its employees or their family members. The member may be responsible for all or part of the subscription charges.

**EXTENSION OF BENEFITS**

If you are a totally disabled subscriber or a totally disabled family member and under the treatment of a dentist on the date of discontinuance of the agreement, your benefits may be continued for treatment of the totally disabling dental condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

1. If you wish to apply for total disability benefits, you must do so by submitting written certification by your dentist of the total disability. We must receive this certification within 90 days of the date coverage ends under this plan. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.
2. Your extension of benefits will end when any one of the following circumstances occurs:
   
   a. You are no longer totally disabled.
   
   b. The maximum benefits available to you under this plan are paid.
   
   c. You become covered under another group plan which provides benefits without limitation for your disabling dental condition.
   
   d. A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

Providing of Care. We are not directly responsible for providing dental services, therefore we are not responsible for the care received.

Independent Contractors. Our relationship with the participating dental office is that of an independent contractor. Participating dentists and other dental health professionals within the participating dental office are not our agents or employees nor are we, or any of our employees, an employee or agent of any participating dental office.

Terms of Coverage

1. In order for you to be entitled to benefits under the agreement, both the agreement and your coverage under the agreement must be in effect on the date the covered service is provided.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the covered service is provided.

3. The agreement is subject to amendment, modification or termination according to the provisions of the agreement without your consent or concurrence.

Protection of Coverage. We do not have the right to cancel your coverage under this plan while:

1. This plan is still in effect; and

2. You are eligible; and

3. Your subscription charges are paid according to the terms of the agreement; and

4. You live or work within your participating dental office’s enrollment area; and
You pay all co-payments due at the time services are received.

**Provider Reimbursement.** Participating dental offices are generally paid a capitation fee, a set and agreed to dollar amount per member each month, for dental services, and may receive additional reimbursement for overall efficiency. Participating specialty offices are paid on a fee-for-service basis, according to an agreed schedule for providing specialty care. Participating dental offices may also receive additional compensation related to the management of services and referrals. The terms of these arrangements may vary by participating dental office. For additional information you may contact us at the telephone number listed on your identification card or your participating dental office.

**Acceptable Services.** The benefits of this plan are provided only for services that we determine to be acceptable services. The services must be prescribed by the participating dentist for the direct care and treatment of a covered dental service. They must be standard dental procedures, recognized by the American Dental Association, received for the dental condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this plan is available to you upon request.

**Expense in Excess of Benefits.** We are not liable for any expense you incur in excess of the benefits of this plan.

**Benefits Not Transferable.** Only members are entitled to receive benefits under this plan. The right to benefits cannot be transferred.

**Plan Administrator - COBRA and ERISA.** In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the group or to a person or entity, other than us, engaged by the group to perform or assist in performing administrative tasks in connection with the group's health plan. The group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation of Coverage section of this booklet, the group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

**Prepayment Fees.** Your employer is responsible for paying subscription charges to us for all coverage provided to you and your family members. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.
Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any participating provider for amounts we owe to that provider, even in the unlikely event that we fail to pay that provider. You are, however, liable for services which are not covered by this plan.

Financial Responsibility. In the event you transfer or terminate enrollment from your participating dental office, any costs to transfer or duplicate the dental records and/or x-rays to the new office will be your financial responsibility and subject to the customary and reasonable fees of the participating dental office, not to exceed $25. If you reside or change your permanent residence or employment location outside of the Dental Net Service area, and decide to have care provided or treatment completed by a dental office other than your participating dental office, you and NOT us will be financially responsible.

Renewal Provisions. Your employer's health plan agreement with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the plan from time to time.

Public Policy Participation. We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Confidentiality of Medical Records. A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new members receiving services from a dental office or dentist who does not have a Participating Dental Net Agreement in effect with us. If you are a new member, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the non-participating dentist and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

3. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

4. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the child enrolls with Anthem.

5. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Anthem.

Please contact customer service at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the plan.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the plan. Financial arrangements with non-participating dentists are negotiated on a case-by-case basis. We will request that the non-participating dentist agree to accept reimbursement and contractual requirements that apply to participating dentists, including payment terms, who are not capitated. If the non-participating dentist does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider’s services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a dentist review the request.
**Continuity of Care after Termination of Provider:** Subject to the terms and conditions set forth below, Anthem will provide benefits at the participating dentist level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a participating dental office at the time the participating dental office’s contract with us terminates (unless the participating dental office’s contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the participating dental office at the time the participating dental office’s contract terminates. The terminated dental office must agree in writing to provide services to you in accordance with the terms and conditions of the agreement with Anthem prior to termination. The dental office must also agree in writing to accept the terms and reimbursement rates that apply to participating dentists who are not capitated. If the dental office does not agree with these contractual terms and conditions, we are not required to continue the dental office’s services beyond the contract termination date.

Anthem will provide such benefits for the completion of covered services by a terminated dental office only for the following conditions:

1. **An acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. **A serious chronic condition.** A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated dental office and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the dental office’s contract terminates.

3. **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
4. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

5. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Such benefits will not apply to dental offices that have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on the member's clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the plan.

We will notify you by telephone, and the dental office by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the plan. Financial arrangements with terminated dental offices are negotiated on a case-by-case basis. We will request that the terminated dental office agree to accept reimbursement and contractual requirements that apply to participating dental offices, including payment terms, who are not capitated. If the terminated dental office does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that dental office's services. If you disagree with our determination regarding continuity of care, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

This provision also applies if the contractual or employment relationship between your participating dental office and the participating dentist or participating specialist from whom you are receiving care terminates.
GRIEVANCE PROCEDURES

1. If you are dissatisfied or have a grievance regarding services under this agreement, contact your participating dental office.

   If you are unable to resolve your concerns with the participating dental office, you should submit a formal complaint to us, in writing, including all pertinent information from your Dental Net identification card and the details and circumstances of your concern or problem. You can get a copy of the grievance form from us. Complete the form and mail it to us or you may call us at the Dental Net Customer Service telephone number listed on your identification card and ask the customer service representative to complete the form for you. You may also submit your grievance to us online or print a copy of the grievance form through the Anthem Blue Cross website at www.anthem.com/ca. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or your participating dental office or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly.

   We will request all pertinent information regarding your concerns from all parties involved. Upon receipt of all requested information, we will review and, if possible, resolve the matter. We should be allowed thirty (30) days after receipt of the complaint and all necessary information to reach a resolution.

   If your concern or problem with the services provided by your participating dental office cannot be resolved by us, we may recommend that the complaint be submitted for impartial review to the California Dental Association’s Peer Review process or to another qualified mediator for impartial review and settlement.

2. If you are dissatisfied or have a concern with Dental Net, contact our Dental Customer Service department indicated on your identification card. If we are unable to resolve your concerns, you should submit a formal complaint as described above requesting review by the Grievance Committee. This committee is comprised of the following: The Dental Net Dental Director, the Compliance Manager, Professional Relations staff representatives, the Manager of Quality Assurance, Customer Service staff representative and three grievance coordinators.
The Grievance Committee shall be allowed thirty (30) days after receipt of the complaint and all necessary information to reach a resolution. Within five (5) days after receipt of the grievance, we will acknowledge receipt. After we have reviewed your grievance we will send you a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

3. If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days, you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE). If your case involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your concerns to the Department of Managed Health Care for review.

4. If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, you may elect binding arbitration (see BINDING ARBITRATION).
Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we or your participating dental office determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. You will receive an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross Dental Net Grievance Department, P.O. Box 9155, Oxnard, CA 93031-9155. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
  - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient’s survival.
  - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

- Your participating dental office must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this plan than the proposed treatment.

- The proposed treatment must either be:
  - Recommended by a participating dentist who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
Requested by you or by a licensed board certified or board eligible dentist qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:

a) Peer-reviewed scientific studies published in medical journals with nationally recognized standards;

b) Medical literature meeting the criteria of the National Institute of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;

c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and

f) Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must request this review within six months of the date you receive a denial notice in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your participating dental office. Any newly developed or discovered relevant medical records identified by us or by a participating dentist after the initial documents are sent will be immediately forwarded to the reviewing panel.
The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your participating dental office determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be experimental, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (“IMR”) of disputed health care services from the Department of Managed Health Care (“DMHC”) if you believe that we or your participating dental office have improperly denied, modified, or delayed health care services. A “disputed health care service” is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us or your participating dental office, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form and an addressed envelope for you to use to request IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility: The DMHC will review your application for IMR to confirm that:

1. One or more of the following conditions has been met:
   
   (a) Your dentist has recommended a health care service as medically necessary,
   
   (b) You have received urgent care or emergency services that a dentist determined was medically necessary, or
   
   (c) You have been seen by a participating dentist for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us or your participating dental office, based in whole or in part on a decision that the health care service is not medically necessary; and

3. You have filed a grievance with us or your participating dental office and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us or your participating dental office in response to your grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, we will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 days.

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

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or the agreement, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The member and Anthem agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.

The member and Anthem agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the member waives any right to pursue, on a class basis, any such controversy or claim against Anthem and Anthem waives any right to pursue on a class basis any such controversy or claim against the member.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.
The arbitration is initiated by the *member* making written demand on Anthem. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the *member* and Anthem, or by order of the court, if the *member* and Anthem cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.
COORDINATION OF BENEFITS

If you are covered by more than one group dental plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each member, per year, and are largely determined by California law.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which we would determine to be eligible expense, if you were covered under This plan only; or (2) the amount any Other Plan would determine to be eligible expense in the absence of other coverage.

Other Plan is any of the following:

1. group, blanket or franchise insurance coverage;
2. group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term “Other Plan” refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or other arrangement which reserves the right to take the services or benefits of Other Plans into consideration in determining its benefits.

Principal Plan is that plan which will have its benefits determined first.

This Plan is that portion of this plan which provides benefits subject to this provision.
EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all of the plans do not exceed the Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

If This Plan is not the Principal Plan, you may be billed by a dentist or other provider of dental care.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

2. A plan which covers you as a subscriber pays before a plan which covers you as a dependent.

3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the year. But, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

   Exception to Rule 3: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:

   a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

   b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are provided will be as follows:

      i. The plan which covers that child as a dependent of the parent with custody.

      ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).
iii. The plan which covers that *child* as a dependent of the parent without custody.

iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent’s financial responsibility for that *child’s* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

**OUR RIGHTS UNDER THIS PROVISION**

**Responsibility for Timely Notice.** We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

**Reasonable Cash Value.** If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

**Facility of Payment.** If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.
**Right of Recovery.** If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, your *participating dental office* and we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

**DEFINITIONS**

The meanings of key terms used in this booklet are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this booklet, you should refer to this section.

**Acceptable services** are services and supplies provided in connection with those services which we determine to be:

1. Acceptable and necessary for the symptoms, diagnosis, or treatment of your dental condition.
2. Provided for the prevention, diagnosis, or direct care and treatment of the dental condition.
3. Within community standards of good dental practice.

**Agreement** is the Group Benefit Agreement issued by us to the *group*.

**Anthem Blue Cross (Anthem)** is a health care service plan, regulated by the California Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Act of 1975.

**Child** meets the plan’s eligibility requirements for children as outlined under WHO’S COVERED AND WHEN.

**Co-payment** is the amount of payment indicated in the SCHEDULE OF CO-PAYMENTS. It is due and payable at the time of service by the *member* to the *participating dental office* or other provider of care.

**Covered Service** is any dental service received by you which meets all of the following criteria:

1. It must be received by you while you are covered under this *plan*. (An expense is considered to be incurred on the date you receive the dental service or supply for which the expense is made.);
2. It must be for a dental service or supply listed as covered in the SCHEDULE OF CO-PAYMENTS;
3. It must NOT be for a dental service or supply listed in the WHAT’S NOT COVERED AND LIMITED SERVICES section of this booklet; and
4. It must be for a dental service or supply received in accordance with the HOW TO OBTAIN CARE section under YOUR DENTAL BENEFITS.
Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the pre-existing condition exclusion period under this plan and/or to set up eligibility for rules children who cannot get a self-sustaining job due to a physical or mental condition.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this plan is no more than 180 days (not including any waiting period imposed under this plan).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this plan is no more than 63 days (not including any waiting period imposed under this plan).

Dental Net of California (Dental Net) is a prepaid dental care plan provided by Anthem.

Dentist is a person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Domestic partner meets the plan’s eligibility requirements for domestic partners as outlined under WHO’S COVERED AND WHEN: HOW YOU ENROLL.

Effective date is the date your coverage begins under this plan.
Emergency services are services required for alleviation of severe pain or bleeding or swelling. Emergency services are not for continuing any treatment plan currently in process, unless it has been authorized. Final determination as to whether services were rendered in connection with an emergency will rest solely with us or your participating dental office.

Enrollment area (service area) is defined as the geographical area within a 35 mile radius of the participating dental office selected by the subscriber.

Experimental or investigative procedures are those that are not recognized and accepted by the American Dental Association (ADA) as standard dental practice.

Family member is the subscriber's enrolled spouse and each enrolled child.

Full-time employee meets the plan’s eligibility requirements for full-time employees as outlined under WHO’S COVERED AND WHEN.

Group refers to the business entity to which we have issued this agreement. The name of the group is IBEW LOCAL 18 HEALTH & WELFARE TRUST.

Member is the subscriber or family member.

Non-participating dentist is a dentist who has not entered into a Participating Dental Net Agreement with us at the time services are rendered.

Orthodontia - Phase I Treatment (Primary and or Transitional Dentition) is the use of either fixed or removable appliances in the upper or lower arches, or both. It includes the treatment of such problems as cross bite, arch width, distance between the arches and deep overbite or overjet.

Orthodontia - Phase II Treatment (Adolescent or Adult Dentition) is the use of generally fixed appliances to definitely move the teeth within the jaws. May include refinement of less severe problems commonly treated in Phase I. (Standard 24 month treatment plan).

Participating dental office is a dentist, or a group of dentists organized as a legal entity, which has an agreement in effect with us to furnish dental care to members, and which has been selected by the subscriber to provide the services covered under this plan.
Participating dentist is a licensed dentist at a participating dental office which has an agreement in effect with us to furnish dental care to members.

Participating orthodontic office is a licensed orthodontist, or a group of orthodontists organized as a legal entity, which has an agreement in effect with us to furnish orthodontic care to members, and which has been selected by the subscriber to provide the orthodontic services covered under this plan.

Participating orthodontist is a licensed dentist (orthodontist) who has completed an advanced education program at an institution accredited by the American Dental Association, or American Orthodontic Association; who has a practice limited to providing orthodontic services and has contracted with us to provide orthodontic services to members; and is an owner, associate or employee of a participating orthodontic office.

Participating specialist is a licensed dentist who has completed an advanced education program at an institution accredited by the American Dental Association, or Government entity, who has a practice limited to providing specialty services, and has contracted with us to provide specialty services to members, and is an owner, associate or employee of the participating specialty office.

Participating specialty office is the dental office which will provide authorized specialty referral services which you are entitled to under this plan. All specialty services received at a participating specialty office must be authorized by us. All participating specialty offices have contracted with us to provide specialty services to members.

Physician means a licensed practitioner of the healing arts acting within the scope of their license.

Plan is the set of benefits described in this booklet and in the amendments to this booklet, if any. This plan is subject to the terms and conditions of the agreement we have issued to the group. If changes are made to the plan, an amendment or revised booklet will be issued to the group for distribution to each subscriber affected by the change. (The word “plan” here does not mean the same as plan as used in ERISA.)

Prior Plan is a plan sponsored by the group which was replaced by this plan within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this plan's effective date; and (3) had coverage terminate solely due to the prior plan’s termination.
Specialty Referral Services are specialty services rendered by a participating specialty office which: (1) have been authorized by us; or (2) have been rendered to a member referred in an emergency by the participating dental office and which constitute emergency services.

Spouse meets the plan’s eligibility requirements for spouses as outlined under WHO’S COVERED AND WHEN.

Subscriber is the person who, by meeting the plan’s eligibility requirements for subscribers, is allowed to choose membership under this plan for himself or herself and his or her eligible family members. Such requirements are outlined in WHO’S COVERED AND WHEN.

Totally disabled family member is a family member who is unable to perform all activities usual for persons of that age.

Totally disabled subscriber is a subscriber who, because of dental illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

We (us, our) refers to Anthem Blue Cross.

Year or calendar year is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the subscriber and family members who are enrolled for benefits under this plan.

Your participating dental office is the participating dental office which will either provide or authorize the dental care to which you are entitled under this plan.

Your participating dentist refers to the participating dentist from the staff of your participating dental office who will be the primary provider of your dental care while you are enrolled as a Dental Net member in that participating dental office.
SCHEDULE OF CO-PAYMENTS FOR PLAN 2600

The services which are provided for the treatment of covered dental benefits are listed below. All services must be authorized by your participating dentist or Anthem. Included in the list of covered services are the co-payment amounts you will be required to pay for office visits, certain missed or canceled appointments and certain services. All services are subject to the WHAT’S NOT COVERED AND LIMITED SERVICES section of your Dental Net Evidence of Coverage Form.

THE SERVICES OF THIS PLAN ARE PROVIDED ONLY WHEN PERFORMED, PRESCRIBED, DIRECTED OR AUTHORIZED AS ACCEPTABLE SERVICES BY A DENTIST IN THE PARTICIPATING DENTAL OFFICE YOU HAVE SELECTED.

DIAGNOSTIC

These are routine services which are required by your dentist to determine the type of treatment you may need.

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<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CO-PAYMENT</th>
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<tr>
<td>Clinical Oral Examinations</td>
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<tr>
<td>Initial oral examination</td>
<td>No Charge</td>
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<tr>
<td>Periodic oral examination</td>
<td>No Charge</td>
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<tr>
<td>Office visit per patient</td>
<td>No Charge</td>
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<tr>
<td>Emergency oral examination</td>
<td>No Charge</td>
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<tr>
<td>X-Rays</td>
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<td>Intraoral – complete series</td>
<td>No Charge</td>
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<td>Intraoral – periapical – first film</td>
<td>No Charge</td>
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<td>Intraoral – periapical – each additional film</td>
<td>No Charge</td>
</tr>
<tr>
<td>Intraoral – occlusal film</td>
<td>No Charge</td>
</tr>
<tr>
<td>Bitewing – single film</td>
<td>No Charge</td>
</tr>
<tr>
<td>Bitewings – two films</td>
<td>No Charge</td>
</tr>
<tr>
<td>Bitewings – four films</td>
<td>No Charge</td>
</tr>
<tr>
<td>Vertical Bitewings</td>
<td>No Charge</td>
</tr>
<tr>
<td>Panoramic film</td>
<td>No Charge</td>
</tr>
<tr>
<td>Tests and Consultations</td>
<td></td>
</tr>
<tr>
<td>Pulp vitality tests</td>
<td>No Charge</td>
</tr>
<tr>
<td>Diagnostic casts</td>
<td>No Charge</td>
</tr>
<tr>
<td>Consultation – per session</td>
<td>No Charge</td>
</tr>
</tbody>
</table>
PREVENTIVE

These services are performed by your dentist or a licensed dental hygienist to help prevent certain conditions from occurring.

** COVERED SERVICES **

**CO-PAYMENT**

<table>
<thead>
<tr>
<th>Dental Prophylaxis</th>
<th>No Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylaxis – adult*</td>
<td>No Charge</td>
</tr>
<tr>
<td>Prophylaxis – child*</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

** Topical Fluoride Treatment **

Topical application of fluoride:
- Including prophylaxis ......................... No Charge
- Excluding prophylaxis ........................ No Charge

** Other Preventive Services **

| Sealants per tooth ................................ | $ 5.00 |
| Oral hygiene instruction .................... | No Charge |

** Space Maintenance (passive appliances) **

| Space maintainer – fixed – unilateral .... | $ 35.00 |
| Space maintainer – fixed – bilateral ...... | $ 35.00 |
| Space maintainer – removable – unilateral | $ 40.00 |
| Space maintainer – removable – bilateral  | $ 40.00 |
| Recement of space maintainer ................ | $ 5.00 |

* For the third cleaning in a twelve (12) month period, the co-payment is 80% of the dentist’s usual fee.

RESTORATIVE

These services are performed by your dentist to restore tooth structure lost as a result of dental decay.

** COVERED SERVICES **

**CO-PAYMENT**

<p>| Amalgam Restorations (including polishing) | No Charge |
| One surface, primary ........................ | No Charge |
| Two surfaces, primary ........................ | No Charge |
| Three surfaces, primary ...................... | No Charge |
| Four or more surfaces, primary ............. | No Charge |
| One surface, permanent ........................ | No Charge |
| Two surfaces, permanent ...................... | No Charge |
| Three surfaces, permanent ................... | No Charge |
| Four or more surfaces, permanent .......... | No Charge |</p>
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resin or Composite Restorations</strong></td>
<td></td>
</tr>
<tr>
<td>One surface, anterior</td>
<td>No Charge</td>
</tr>
<tr>
<td>Two surfaces, anterior</td>
<td>No Charge</td>
</tr>
<tr>
<td>Three surfaces, anterior</td>
<td>No Charge</td>
</tr>
<tr>
<td>Four or more surfaces or involving incisal angle, anterior</td>
<td>$ 10.00</td>
</tr>
<tr>
<td>Resin, one surface, posterior, primary</td>
<td>$ 30.00</td>
</tr>
<tr>
<td>Resin, two surfaces, posterior, primary</td>
<td>$ 40.00</td>
</tr>
<tr>
<td>Resin, three or more surfaces, posterior, primary</td>
<td>$ 50.00</td>
</tr>
<tr>
<td>Resin, one surface, posterior, permanent</td>
<td>$ 50.00</td>
</tr>
<tr>
<td>Resin, two surfaces, posterior, permanent</td>
<td>$ 65.00</td>
</tr>
<tr>
<td>Resin, three or more surfaces, posterior, permanent</td>
<td>$ 75.00</td>
</tr>
<tr>
<td>Resin, based composite four or more surfaces, posterior permanent</td>
<td>$ 85.00</td>
</tr>
<tr>
<td>Resin based composite crown, anterior, primary</td>
<td>$ 50.00</td>
</tr>
<tr>
<td>Resin based composite crown, anterior, permanent</td>
<td>$ 60.00</td>
</tr>
<tr>
<td><strong>Other Restorative Services</strong></td>
<td></td>
</tr>
<tr>
<td>Prefabricated stainless steel crown:</td>
<td></td>
</tr>
<tr>
<td>– Primary tooth</td>
<td>$ 10.00</td>
</tr>
<tr>
<td>– Permanent tooth</td>
<td>$ 10.00</td>
</tr>
<tr>
<td>Prefabricated resin crown</td>
<td>$ 10.00</td>
</tr>
<tr>
<td>Sedative filling</td>
<td>No Charge</td>
</tr>
<tr>
<td>Crown buildup, including any pins</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>Pin retention – per tooth, in addition to restoration</td>
<td>$ 10.00</td>
</tr>
</tbody>
</table>
ENDODONTICS

These services are performed by your dentist to treat diseases of the tooth pulp nerve and their associated structures.

**COVERED SERVICES**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pulp Capping</strong></td>
<td></td>
</tr>
<tr>
<td>Pulp cap – direct</td>
<td>No Charge</td>
</tr>
<tr>
<td>Pulp cap – indirect</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>Pulpotomy</strong></td>
<td></td>
</tr>
<tr>
<td>Gross pulp debridement, primary &amp; permanent</td>
<td>$ 18.00</td>
</tr>
<tr>
<td>Therapeutic pulpotomy</td>
<td>$ 5.00</td>
</tr>
<tr>
<td><strong>Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care)</strong></td>
<td></td>
</tr>
<tr>
<td>One canal (anterior)</td>
<td>$ 80.00</td>
</tr>
<tr>
<td>Two canals (bicuspid)</td>
<td>$ 100.00</td>
</tr>
<tr>
<td>Three or four canals (molar)</td>
<td>$ 200.00</td>
</tr>
<tr>
<td>Retreatment - one canal (anterior)</td>
<td>$ 90.00</td>
</tr>
<tr>
<td>Retreatment - two canals (bicuspid)</td>
<td>$ 110.00</td>
</tr>
<tr>
<td>Retreatment - three or four canals (molar)</td>
<td>$ 135.00</td>
</tr>
<tr>
<td>Incomplete Endodontic Therapy (unretainable tooth)</td>
<td>$ 40.00</td>
</tr>
<tr>
<td><strong>Periapical Services</strong></td>
<td></td>
</tr>
<tr>
<td>Apicoectomy (per tooth) – first root</td>
<td>$ 90.00</td>
</tr>
<tr>
<td>Apicoectomy (per tooth) – each additional root</td>
<td>$ 40.00</td>
</tr>
<tr>
<td>Retrograde filling – per root</td>
<td>$ 100.00</td>
</tr>
<tr>
<td><strong>Other Endodontic Services</strong></td>
<td></td>
</tr>
<tr>
<td>Surgical procedure for isolation of tooth with rubber dam</td>
<td>No Charge</td>
</tr>
<tr>
<td>Canal preparation &amp; fitting of preformed dowel or post</td>
<td>No Charge</td>
</tr>
</tbody>
</table>
PERIODONTICS

These services are performed by your dentist or a licensed dental hygienist to treat diseases of the gums and supporting structures.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (including usual postoperative services)</td>
<td></td>
</tr>
<tr>
<td>Gingivectomy or gingivoplasty – per quadrant</td>
<td>$75.00</td>
</tr>
<tr>
<td>Gingivectomy or gingivoplasty – per tooth</td>
<td>$20.00</td>
</tr>
<tr>
<td>Gingival curettage – per quadrant</td>
<td>$15.00</td>
</tr>
<tr>
<td>Osseous surgery – per quadrant</td>
<td>$180.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjunctive Periodontal Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodontal scaling and root planing – per quadrant</td>
<td>$20.00</td>
</tr>
<tr>
<td>Periodontal maintenance following active therapy</td>
<td>$20.00</td>
</tr>
<tr>
<td>Full mouth debridement for perio evaluation &amp; diagnosis</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

PROSTHODONTICS

These services are performed by your dentist to repair tooth structure lost as a result of dental decay or replace missing teeth with full or partial dentures, crowns and bridges.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inlay Restorations</td>
<td></td>
</tr>
<tr>
<td>Inlay metallic - one surface</td>
<td>$65.00</td>
</tr>
<tr>
<td>Inlay metallic – two surfaces</td>
<td>$75.00</td>
</tr>
<tr>
<td>Inlay metallic – three or more surfaces</td>
<td>$85.00</td>
</tr>
<tr>
<td>Onlay metallic - two surfaces</td>
<td>$125.00</td>
</tr>
<tr>
<td>Onlay metallic - three surfaces</td>
<td>$125.00</td>
</tr>
<tr>
<td>Onlay metallic – four or more surfaces</td>
<td>$125.00</td>
</tr>
</tbody>
</table>

* Plus actual costs for noble/high (precious) metal not to exceed $100.
PROSTHODONTICS (Continued)

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crowns – Single Restoration Only</strong></td>
<td></td>
</tr>
<tr>
<td>Crown – porcelain/ceramic substrate</td>
<td>$ 200.00</td>
</tr>
<tr>
<td>Crown – porcelain fused to high noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown – porcelain fused to predominantly base metal</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown – porcelain fused to noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown - 3/4 cast high noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown - 3/4 cast high predominantly base metal</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown - 3/4 cast noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown - 3/4 porcelain/ceramic</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown – full cast high noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown – full cast predominantly base metal</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Crown – full cast noble metal*</td>
<td>$ 150.00</td>
</tr>
</tbody>
</table>

| **Other Prosthodontic Services** | |
| Cast post and core* | $ 35.00 |
| Each additional cast post (same tooth)* | No Charge |
| Prefabricated post and core | $ 35.00 |
| Each additional prefabricated post (same tooth) | No Charge |
| Post removal (not in conjunction with endodontic therapy) | $ 10.00 |
| Temporary crown (fractured tooth) | $ 20.00 |
| Recement inlay | $ 5.00 |
| Recement crown | $ 5.00 |

| **Complete Dentures (including routine postdelivery care)** | |
| Complete upper** (placed after healing period) | $ 200.00 |
| Complete lower** (placed after healing period) | $ 200.00 |
| Immediate upper** (placed immediately after extractions) | $ 200.00 |
| Immediate lower** (placed immediately after extractions) | $ 200.00 |

| **Partial Dentures (including routine postdelivery care)** | |
| Upper partial denture - resin base including clasps | $ 225.00 |
| Lower partial denture - resin base including clasps | $ 225.00 |
| Upper partial predominantly cast base including clasps | $ 250.00 |
| Lower partial predominantly cast base including clasps | $ 250.00 |

* Plus actual costs for noble/high (precious) metal not to exceed $100.00.

** Either type of denture is an acceptable restoration, however; Dental Net benefits the first one placed, not both.
### Adjustments to Dentures
- Adjust complete upper denture: $10.00
- Adjust complete lower denture: $10.00
- Adjust partial upper denture: $10.00
- Adjust partial lower denture: $10.00

### Repairs to Complete Dentures
- Repair broken complete denture base: $15.00
- Replace missing or broken teeth (each tooth): $15.00

### Repairs to Partial Dentures
- Repair resin saddle or base: $15.00
- Repair cast framework: $30.00
- Repair or replace broken clasp: $20.00
- Replace broken teeth-per tooth: $15.00
- Add tooth to existing partial denture: $15.00
- Add clasp to existing partial denture: $30.00

### Denture Rebase Procedures
- Rebase complete upper denture: $80.00
- Rebase complete lower denture: $80.00
- Rebase partial upper denture: $80.00
- Rebase partial lower denture: $80.00

### Denture Reline Procedures
- Reline complete upper denture (chairside): $25.00
- Reline complete lower denture (chairside): $25.00
- Reline partial upper denture (chairside): $25.00
- Reline partial lower denture (chairside): $25.00
- Reline complete upper denture (laboratory): $50.00
- Reline complete lower denture (laboratory): $50.00
- Reline partial upper denture (laboratory): $50.00
- Reline partial lower denture (laboratory): $50.00

### Other Removable Prosthetic Services
- Interim partial – stayplate denture (upper): $100.00
- Interim partial – stayplate denture (lower): $100.00
- Tissue conditioning – per denture unit: $30.00
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bridge Pontics</strong></td>
<td></td>
</tr>
<tr>
<td>Pontic – cast high noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Pontic – cast predominantly base metal</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Pontic – cast noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Pontic – porcelain fused to high noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Pontic – porcelain fused to predominantly base metal</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Pontic – porcelain fused to noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>Pontic – porcelain/ceramic</td>
<td>$ 200.00</td>
</tr>
<tr>
<td><strong>Bridge Retainers – Crowns</strong></td>
<td></td>
</tr>
<tr>
<td>Abutment crowns:</td>
<td></td>
</tr>
<tr>
<td>– Porcelain/ceramic</td>
<td>$ 200.00</td>
</tr>
<tr>
<td>– Porcelain fused to high noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– Porcelain fused to predominantly base metal</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– Porcelain fused to noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– 3/4 cast high noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– 3/4 cast predominantly base metal</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– 3/4 cast noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– 3/4 porcelain/ceramic</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– Full cast high noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– Full cast predominantly base metal</td>
<td>$ 150.00</td>
</tr>
<tr>
<td>– Full cast noble metal*</td>
<td>$ 150.00</td>
</tr>
<tr>
<td><strong>Other Fixed Prosthetic Services</strong></td>
<td></td>
</tr>
<tr>
<td>Recement bridge</td>
<td>$ 5.00</td>
</tr>
</tbody>
</table>

* Plus actual costs for noble/high (precious) metal not to exceed $100.00.
ORAL SURGERY

Oral surgery is performed by your dentist when you require an extraction, biopsy or other oral surgery.

COVERED SERVICES CO-PAYMENT

Extractions (includes local anesthesia and routine postoperative care)
Single tooth (simple) .............................................................. No Charge
Each additional tooth (simple) ................................................ No Charge
Root removal – exposed roots ............................................. No Charge

Surgical Extractions (includes local anesthesia and routine postoperative care)
Surgical removal of erupted tooth ........................................ $ 25.00
Removal of impacted tooth:
- Soft tissue ................................................................. $ 30.00
- Partially bony ............................................................. $ 65.00
- Completely bony* ..................................................... $ 75.00
- Completely bony, with complications* ....................... $ 75.00
Root recovery (surgical removal of residual tooth roots) .... $ 45.00
Alveoloplasty in conjunction with extraction-per quad** .... $ 65.00
Alveoloplasty not in conjunction with extraction-per quad** .. $ 80.00

Other Surgical Procedures
Biopsy of oral tissue-hard*** ........................................... $ 20.00
Biopsy of oral tissue-soft*** .............................................. $ 20.00
Incision/drain of abscess – intraoral soft tissue ............... $ 25.00

* Independent procedures co-payments cannot be combined.
** In preparation for dentures.
*** Histopathological exam is not included and is not benefited.

ANESTHESIA

Your dentist may recommend you be given an anesthetic before necessary dental procedures are performed. You may only need a local anesthetic applied directly to the area in which your dentist will be working.

COVERED SERVICES CO-PAYMENT

Anesthesia
Local anesthesia .......................................................... No Charge
Regional block anesthesia .............................................. No Charge
MISCELLANEOUS SERVICES

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit – after hours</td>
<td>$ 45.00</td>
</tr>
<tr>
<td>Emergency palliative treatment</td>
<td>$ 5.00</td>
</tr>
<tr>
<td>Other drugs and/or medicaments, by report*</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>Broken appointments, less than 24 hours notice</td>
<td>$ 25.00</td>
</tr>
</tbody>
</table>

* Not prescription drugs

IMPORTANT: IF YOUR DENTAL OFFICE CHARGES FOR A BROKEN APPOINTMENT OR FAILURE TO CANCEL WITHOUT PROVIDING 24 HOURS ADVANCE NOTICE, THEN YOU WILL BE RESPONSIBLE FOR THIS CHARGE. THIS CHARGE IS NOT REIMBURSABLE BY US.
YOUR ORTHODONTIC BENEFITS

Your Dental Net plan provides the orthodontic benefits described below. Please read the following information so that you may know how to take advantage of these added benefits. These benefits are subject to all the terms, conditions, limitations and exclusions of your Evidence of Coverage Form.

Orthodontic services are provided to prevent or correct the abnormal positioning or misalignment of teeth (malocclusion).

ANY ORTHODONTIC TREATMENT MUST BE PROVIDED BY A PARTICIPATING ORTHODONTIST CONTRACTED BY US TO PROVIDE ORTHODONTIC SERVICES TO DENTAL NET MEMBERS.

HOW YOU OBTAIN CARE

If you or a family member require the services of an orthodontist, you should first contact the Dental Net Customer Service department at (800) 627-0004 for written referral for orthodontic care. The Dental Customer Service Representative will provide you with the written orthodontic referral and information you need to take with you to your first appointment with the participating orthodontist. This information may include a listing of the participating orthodontic offices through which you are eligible to receive your orthodontic benefits, a letter of eligibility indicating your benefits (to present to the orthodontist), and the eligibility verification form your participating orthodontist must submit to us for your benefits. ORTHODONTIC TREATMENT PROVIDED WITHOUT A WRITTEN REFERRAL FROM US WILL BE YOUR FINANCIAL RESPONSIBILITY AND NOT OURS.

Once you receive your orthodontic eligibility information, contact a participating orthodontist from the list, who is convenient to your location, to schedule an appointment. ONLY THE ORTHODONTISTS ON THIS LIST ARE AUTHORIZED TO PROVIDE COVERED ORTHODONTIC SERVICES FOR YOU AND YOUR FAMILY MEMBERS.

When you come in for your appointment, you will be required to show your Dental Net identification card and provide your orthodontist with the orthodontic eligibility information sent to you by us.

If you need to cancel or reschedule an appointment, please notify the orthodontist as far in advance as possible. YOUR PARTICIPATING ORTHODONTIC OFFICE MAY CHARGE FOR A BROKEN APPOINTMENT, OR AN APPOINTMENT NOT CANCELLED WITH AT LEAST 24 HOURS NOTICE. These charges are your responsibility and NOT ours.
WHAT’S COVERED

Your orthodontic benefits include the following services when provided by a participating orthodontist:

Orthodontic Consultation. Initial consultation to determine the extent of required orthodontic services.

Standard Orthodontic Treatment. Up to twenty-four (24) months of standard orthodontic services for correction of malocclusions, provided during your lifetime.

Pre-orthodontic Visit and Treatment Plan. Includes all necessary diagnostic x-rays, study models, records, analysis and photos at applicable co-payment.

Orthodontic Retention. Includes removal of appliances, construction and placement of retainers at applicable co-payment.

YOUR CO-PAYMENTS

Your co-payments for twenty-four months (24) of standard orthodontic services excluding records/retention fees are listed as follows:

Adults age 18 and over ............................................................... $1450.00
Children through age 17 ............................................................ $1450.00

Other Services:

Pre-orthodontic visit and treatment plan ........................................ $300.00
Orthodontic retention .............................................................. $275.00

The patient charge for orthodontics is determined from the SCHEDULE OF CO-PAYMENTS. Financial arrangements will be agreed upon between you and your participating orthodontist.

LIMITATIONS AND EXCLUSIONS

In addition to the items listed under YOUR DENTAL BENEFITS: WHAT’S NOT COVERED AND LIMITED SERVICES, your orthodontic benefits are subject to the following limitations and exclusions:

ORTHODONTIC LIMITATIONS

Authorized Orthodontic Services. Orthodontic services must be received from a participating orthodontic office as specifically authorized and referred by us in writing.
Lifetime Maximum. Orthodontic treatment is limited to one full case (up to 24 months of standard orthodontic care) during your lifetime.

Loss of Coverage During Orthodontic Treatment. If your coverage under the plan ends, for any reason, while you are still receiving orthodontic treatment during the 24 month treatment period, you and NOT Anthem will be responsible for the remainder of the cost for that treatment, at contracted fee for the remaining months of treatment.

Orthodontic Consultation/Observation Fees. If treatment is not required or you choose not to start treatment after a diagnosis and consultation have been completed by the provider, you may be charged a consultation fee of $30 in addition to diagnostic record fees.

Orthodontic Retention Phase of Care. Retention services include initial fabrication, placement, observation, and adjustments of passive retention appliances for a 12 month period. The retention services fee of $275 is your responsibility and is payable at the beginning of the retention phase of treatment.

Orthodontic Services in Excess of 24 Months of Active Care. You are required to pay the participating orthodontist up to $55 per month for each additional month of standard active orthodontic treatment provided beyond the 24 month period, but before the retention phase of treatment begins.

ORTHODONTIC EXCLUSIONS

Changes in Treatment. Changes in treatment necessitated by an accident of any kind or patient noncompliance.

Myofunctional Therapy. Myofunctional therapy and related services. (Myofunctional therapy involves the use of muscle exercises as an adjunct to orthodontic mechanical correction of malocclusion.)

Orthodontic Retreatment. The retreatment of a previously treated orthodontic case (whether treated under this coverage, at fee-for-service, or under another benefit plan) is not covered.

Orthodontic Services Provided Before or After the Term of Your Coverage. Treatment of orthodontic cases begun prior to your effective date or after termination of your coverage.

Orthodontic Treatment Incidental to Surgical Procedures. Orthodontic treatment in conjunction with oral surgical procedures including, but not limited to, orthognathic surgery.

Phase I Orthodontics/Orthopaedic/Orthodontic Treatment. Any Phase I treatment or orthopaedic/orthodontic treatment which may be
deemed advantageous or necessary by the participating orthodontist prior to the 24 months of standard active treatment. Orthodontic treatment for malocclusions which, in the opinion of the participating orthodontist will not produce beneficial results.

**Other Orthodontic Services.** Services for braces, other orthodontic appliances, or orthodontic services, except as specifically stated in this Evidence of Coverage Form.

**Replacement of Orthodontic Appliances.** Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances broken due to your negligence.

**Special Orthodontic Appliances.** Special types of orthodontic appliances which are considered cosmetic including, but not limited to, lingual or “invisible” braces, sapphire or clear braces, or ceramic braces.

**Surgical Procedures Incidental to Orthodontic Treatment.** Surgical procedures incidental to orthodontic treatment including, but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, ligation, correction of micrognathia or macrognathia, or repair of cleft palate.

**T.M.J. or Hormonal Imbalance Orthodontic Services.** Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance.