IBEW LOCAL 18 HEALTH & WELFARE TRUST

July 1, 2009

Prudent Buyer Dental Plan

CERTIFICATE OF INSURANCE

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, California 91367

This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your dental plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Policy, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. Your employer will provide you with a copy of the Group Policy upon request.

Your dental care coverage is insured by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). The following pages describe your health care benefits and includes the limitations and all other *policy* provisions which apply to you. The *insured person* is referred to as "you" or "your," and Anthem Blue Cross Life and Health as "we," "us" or "our." All italicized words have specific *policy* definitions. These definitions can be found in the DEFINITIONS section of this certificate.

COMPLAINT NOTICE

Should you have any complaints or questions regarding your dental coverage, and this certificate was delivered by a broker, you should first contact the broker. You may also contact us at:

Anthem Blue Cross Life and Health Insurance Company
Customer Service
21555 Oxnard Street
Woodland Hills, CA 91367

818-234-2700

If the problem is not resolved, you may also contact the California Department of Insurance at:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013

1-800-927-HELP (4357) – In California

1-213-897-8921 – Out of California

1-800-482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry: "Consumer Services" link at www.insurance.ca.gov

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TYPES OF PROVIDERS

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

Participating Dentists. Anthem Blue Cross Life and Health has established a network of various types of "Participating Dentists". These dentists are called "participating" because they have agreed to participate in our preferred dentist organization program (PPO), which we call the Prudent Buyer Plan. They have agreed to provide *insured persons* with dental care at a negotiated fee. The amount of benefits payable under this *plan* will be different for *non-participating dentists* than for *participating dentists*.

We publish a directory of Participating Dentists. You can get a directory from your plan administrator (usually your employer).

Non-Participating Dentists. *Non-participating dentists* are dentists which have not agreed to participate in our Prudent Buyer Plan network. They have not agreed to the *dental negotiated rates* and other provisions of a Prudent Buyer Plan contract.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE MEDICALLY NECESSARY. THE FACT THAT YOUR DENTIST PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS A MEDICALLY NECESSARY SERVICE OR THAT THE SERVICE IS A COVERED DENTAL EXPENSE.

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Second Opinions. If you have a question about your dental condition or about a plan of treatment which your *dentist* has recommended, you may receive a second dental opinion from another *dentist*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second dental opinion, remember that greater benefits are provided when you choose a *participating dentist*. You may also ask your *dentist* to refer you to a *participating dentist* to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this *plan* may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

DENTAL BENEFITS

DENTAL DEDUCTIBLES (per *calendar year*)

Applicable to Non-Participating Providers Only:

- Insured Person Deductible **$25**
- Family Deductible **$75**

Exception: The Dental Deductible does not apply to Diagnostic and Preventive Services.

PAYMENT RATES

After the Dental Deductible has been satisfied, we will pay the percentage of *covered dental expense* shown below, for the type of services received, up to the Dental Benefit Maximum:

Participating Dentists

- Diagnostic & Preventive Services **100%**
- Restorative Services.....**90%**
- Prosthodontic Services (Fixed & Removable).....**60%**
- Endodontic Services.....**90%**
- Periodontic Services.....**90%**
- Oral Surgery **90%**
- Orthodontic Services **80%**

Non-Participating Dentists

- Diagnostic & Preventive Services **100%**
- Restorative Services.....**80%**
- Prosthodontic Services (Fixed & Removable).....**60%**
- Endodontic Services.....**80%**
- Periodontic Services.....**80%**
- Oral Surgery **80%**
- Orthodontic Services **80%**

DENTAL BENEFIT MAXIMUMS

- Calendar Year Maximum.....**$2,000**
- Orthodontic Lifetime Maximum.....**$2,000**

YOUR DENTAL BENEFITS

We will pay for *covered dental expense* you incur while covered under this *plan*, subject to all terms, conditions, limitations and exclusions specified in this certificate.

HOW COVERED DENTAL EXPENSE IS DETERMINED

Covered dental expense is based on a maximum charge for each covered service or supply which we will accept. It is not necessarily the amount a *dentist* bills for the service.

Covered dental expense will always be the lesser of the billed charge or the amount shown below.

Participating dentists have agreed not to charge you more than the *dental negotiated rate*. When you choose a *participating dentist*, you will not be responsible for any amount in excess of the *dental negotiated rate* for the covered services of a *participating dentist.*

Your share of the cost of your dental care may be greater if you choose a *non-participating dentist*. You will be responsible for any billed charge which exceeds *covered dental expense* for services provided by a *non-participating dentist.*

DENTAL DEDUCTIBLES AND BENEFIT MAXIMUMS

After we subtract the Dental Deductible from the total amount of *covered dental expense*, we will pay benefits at the Payment Rate which applies to such expense, up to the applicable Dental Benefit Maximums. The Deductible amount, Payment Rates, and Dental Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DENTAL DEDUCTIBLES

(Applicable to Non-Participating Providers Only)

Only charges that are considered *covered dental expense* will apply toward satisfaction of the Dental Deductible.

Insured Person Deductible. Each *calendar year*, you will be responsible for satisfying the Insured Person Deductible before we begin to pay benefits under the *plan*.

Family Deductible. If enrolled members of a family pay Deductible expense during a *calendar year*, equal to the Family Deductible amount shown in the SUMMARY OF BENEFITS, then the Dental Deductible for all *insured family members* is considered to have been met. No further Dental Deductible is required for the remainder of the *year*.

Prior Plan Dental Deductibles. If you were covered for dental benefits under the *prior plan* any amount paid for dental benefits during the same *calendar year* toward your dental deductible under the *prior plan*, will be applied toward your Dental Deductible under this *plan*; provided that, such payments were for charges that would be *covered dental expense* under this *plan*.

DENTAL BENEFIT MAXIMUMS

Calendar Year Maximum. Your benefits, excluding orthodontics, are subject to the Calendar Year Maximum shown in the SUMMARY OF BENEFITS. We will not pay any benefit in excess of that amount for *covered dental expense* incurred during a *calendar year* for each *insured person*. Also, all payments are subject to any waiting periods and limitations specified in this certificate.

Orthodontic Lifetime Maximum. Your orthodontic benefits are subject to the Orthodontic Lifetime Maximum shown in the SUMMARY OF BENEFITS. We will not pay any orthodontic benefits in excess of that amount during an *insured person's* lifetime.

DENTAL CONDITIONS OF SERVICE

The following conditions of service must be met for expense incurred to be considered as *covered dental expense*.

1. You must incur this expense while you are covered for dental benefits under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.

2. The service must be provided by a licensed *dentist*, physician, or dental hygienist and must be for preventive care or for treatment of dental disease, defect or injury.

3. The expense must be incurred for a dental service or supply that is included under DENTAL CARE THAT IS COVERED. Additional limits on *covered dental expense* are included under specific benefits in the SUMMARY OF BENEFITS.

4. The expense must not be for a dental service or supply listed under DENTAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered dental expense*.

5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.

PRE-TREATMENT REVIEW

You may have a pre-treatment review done before you receive benefits. “Pre-treatment review” is not a prior authorization for services but is a system that allows you and your *dentist* to know, in advance, what the estimated benefits payable would be under this *plan* for a proposed course of treatment. The actual benefits you receive under the plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

Under pre-treatment review, your *dentist* prepares a request for a pre-treatment benefit estimation form, and submits this form to us before any treatment begins. The pre-treatment benefit estimation form should: (a) list the recommended dental services; and (b) show the charge for each dental service. We will review this request and send a copy of our estimated benefits to you and your *dentist*. We may request supporting pre-operative x-rays or other diagnostic records in connection with the pre-treatment review. A pre-treatment review is recommended if the proposed course of treatment is expected to involve charges of **$350 or more**.

If the course of treatment is not reviewed before treatment is received, it will be reviewed when the claim is submitted to us for payment and the benefits may be less than you expect.

DENTAL CARE THAT IS COVERED

Each of the following services or supplies is covered subject to DENTAL CONDITIONS OF SERVICE, provided it meets the requirements explained under HOW COVERED DENTAL EXPENSE IS DETERMINED, and is not for, or in connection with, an exclusion or limitation listed under DENTAL CARE THAT IS NOT COVERED.

Diagnostic and Preventive Services

- Examinations
- X-rays
- Teeth cleaning, limited to two per *calendar year*
- Fluoride application, limited to two per *calendar year*
- Sealants

Restorative Services

- Fillings

Prosthodontic Services (Fixed and Removable)

- Preparation and installation of bridges
- Crowns attached to a bridge
- Crowns not attached to a bridge
- Preparation and installation of partial or complete dentures (including repairs)
- Cast restorations, porcelain inlays

Endodontic Services

- Root canal therapy
- Treatment to prevent or correct conditions that affect the tooth pulp, root and related tissue

Periodontic Services

- Scaling and other procedures to prevent or treat diseases or defects to your gums

Oral Surgery

- Extractions of teeth and minor oral surgery. (General anesthesia will be covered with the oral surgery if determined to be *medically necessary*.)

Orthodontic Services

- One case per lifetime
- Consultation
- All adjustments
- All retainers
- Subject to the Orthodontic Lifetime Maximum shown in the SUMMARY OF BENEFITS

DENTAL CARE THAT IS NOT COVERED

No payment will be made under YOUR DENTAL BENEFITS for expense incurred for, or in connection with, any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Services Provided Before or After the Term of This Coverage. Services received before your *effective date* or during an inpatient hospital stay that began before your *effective date*. Services received after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

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

Medically Necessary. Any services or supplies which are not *medically necessary*. (See DEFINITIONS.)

Workers' Compensation. Any work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise under any workers' compensation, employer's liability law or occupational disease law, even if you did not claim those benefits.

Government Programs. Services provided by, or payment made by, any local, state, county or federal government agency including Medicare and any foreign government agency.

No Charge Services. Services received for which no charge is made to you or for which no charge would be made to you in the absence of insurance coverage.

Results Of War. Disease contracted or injuries sustained as a result of war, declared or undeclared or from exposure to nuclear energy, whether or not the result of war.

Provider Related To Insured Person. Professional services received from a person who lives in your home or who is related to you by blood or marriage.

Excess Expense. Any amounts in excess of *covered dental expense* or the Dental Benefit Maximums.

Professionally Acceptable Treatment. If more than one treatment plan would be considered *medically necessary* for a dental condition, any amount exceeding the cost of the least expensive professionally acceptable treatment plan is not covered.

Transfer Of Care. If you transfer from the care of one *dentist* to another *dentist* during the course of treatment, or if more than one *dentist* renders services for one dental procedure, we shall be liable only for the amount for which we would have been liable if one *dentist* had rendered the services.

Hospital Charges. Hospital costs and any additional charges by the *dentist* for hospital treatment.

Services Not Included as a Covered Procedure. Services not included under DENTAL CARE THAT IS COVERED unless they are similar in nature to an included procedure; in such event the benefit payable will be based on the most nearly comparable services included.

Treatment By An Unlicensed Dentist. Charges for treatment by other than a licensed *dentist* or *physician*, except charges for dental prophylaxis performed by a licensed dental hygienist under the supervision and direction of a *dentist*.

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. Procedures requiring appliances or restorations (other than those for replacement of structure lost due to dental decay) that are necessary to alter, restore or maintain occlusion. These include but are not limited to:

- Changing the vertical dimension
- Replacing or stabilizing tooth structure lost by attrition, abrasion, or erosion
- Realignment of teeth
- Gnathological recording
- Occlusal equilibration
- Periodontal splinting

Prosthetic Replacements. Replacement of fixed or removable prosthesis for which benefits were paid, if replacement occurs within five years of the original placement, unless the prosthesis is a stayplate used during the healing period for recently extracted anterior teeth.

Crown Replacements. Replacement of crowns and cast restorations including porcelain crowns and inlays for which benefits were paid by Anthem Blue Cross Life and Health or an affiliated company, if replacement occurs within five years of the original placement.

Denture Repairs, Adjustments or Relines. Repairs, adjustments or relines of full or partial dentures or other prosthesis are not covered for a period of six months from the initial placement if they were paid for under this *plan*.

Lost or Stolen Dentures or Appliances. Replacement of existing full or partial dentures or prosthetic appliances which have been lost or stolen if replacement occurs within five years of the original placement.

Space Maintainers. Use of space maintainers in excess of one treatment per lifetime, which includes one adjustment within six (6) months of placement.

Prosthetics (patients under sixteen years old). Fixed bridges, removable cast partials, cast crowns, with or without veneers, and inlays for patients under sixteen years old.

Implants. Implants (materials implanted into or on bone or soft tissue), or the removal of implants. However, if implants are provided in connection with a covered prosthetic appliance, we will allow the cost of a standard complete or partial denture, or a bridge, toward the cost of the implants and the prosthetic appliances.

Malignancies and Neoplasms. Services for treatment of malignancies and neoplasms.

Cosmetic Dentistry. Any services performed for cosmetic purposes, unless they are for correction of functional disorders or as a result of an *accidental injury* occurring while you were covered for dental benefits under this *plan*.

Congenital or Developmental Malformation. Services to correct a congenital or developmental malformation including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (discoloration of the teeth), and anodontia (congenitally missing teeth).

X-rays. More than one set of full-mouth X-rays or its equivalent in a three (3) year period. Periapical x-rays submitted individually will be combined and paid up to the amount of a full mouth series.

Bite Wing X-rays. Bite wing X-rays in excess of two (2) series for standard or eight (8) films for vertical bite wings twice in any twelve (12) month period.

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

Prophylaxis or Periodontal Prophylaxis. Prophylaxis or periodontal prophylaxis treatments exceeding two treatments in a *calendar year*. Periodontal prophylaxis must be preceded by active periodontal treatment, such as scaling and root planing or osseous (gum) surgery.

Periodontal Surgery. Periodontal surgery exceeding one time per quadrant in a thirty six (36) month period.

Periodontal Scaling. Periodontal scaling exceeding one time per quadrant in a twenty four (24) month period.

Sealants. Sealants are limited to children under 16 years of age for permanent molars, unrestored. Treatment is limited to once every thirty six (36) months per tooth.

Prescription Drugs and Medications. Any prescribed drugs, pre-medication or analgesia.

Root Canal Therapy. Root canal therapy in excess of one treatment per tooth for initial treatment and one retreatment per tooth.

Oral Hygiene. Oral hygiene instruction.

Oral Surgery. Extraction of third molars (wisdom teeth) if the patient is under the age of sixteen (16).

Teeth Lost Prior to this Coverage. Teeth lost prior to coverage under this *plan* are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage.

Precision Attachments. Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.

Overdentures. Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

Restorations. Restorations exceeding one every twelve (12) months per surface per tooth for patients under the age of nineteen (19) and one every thirty six (36) months per surface per tooth for patients over the age of nineteen (19).

Replacement of Existing Restorations. Replacement of existing restorations for any purpose other than restoring active decay.

Harmful Habit Appliances. Fixed and Removable appliances to inhibit thumb sucking.

ORTHODONTIC CARE THAT IS NOT COVERED

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

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, correction of micrognathia or macrognathia, or repair of cleft palate.

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

TMJ or Hormonal Imbalance Orthodontic Services. Orthodontic treatment related to temporomandibular joint disturbances (TMJ) and/or hormonal imbalance.

Orthodontic Records. Orthodontic records including, but not limited to, cephalometric tracing, photographs, study models and diagnostic radiographs.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, an *insured person* 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. In that event, we will provide the benefits of this *plan* subject to the following:

1. We 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 the amount of benefits we paid 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 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 we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.

3. We 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.

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 *insured person*, per *calendar 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 expenses 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 arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the 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 the plans do not exceed 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.

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 an *insured employee* 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 *calendar 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 paid 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, 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.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Insured Employees.** 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 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 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 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 *employee's spouse* or *domestic partner;* and (b) An unmarried *child*.

Definition of Family Member

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

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

   a. The child depends on the *employee, spouse* or *domestic partner* for financial support or the *employee, 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 *employee'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

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 *employee, 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, 60-days of the date the *employee* 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 *employee, 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 *employee*, *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 *employee's*, the *spouse's* or *domestic partner's* right to control the health care of the child.

f. A child for whom the *employee*, *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 an *employee*; or (ii) in active service in the armed forces.

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

ELIGIBILITY DATE

1. **For Employees:** 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 date of 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 *employee* 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 an *employee*, or to enroll *family members*, the *employee* 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 premium 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 *employees*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *employee's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *policy* takes effect, coverage begins on the effective date of the *policy*.

2. **Late Enrollment.** If you file an enrollment application or membership change form with the *group* more than 31 days after your eligibility date, you will be eligible to apply for coverage during the *group's* next Open Enrollment Period.

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 an *employee* under this *plan* may enroll. An *employee* may also enroll any eligible *family members* at that time. Persons eligible to enroll as *family members* may enroll only under the *employee's plan*.

For anyone so enrolling, coverage under this *plan* will begin on July 1. Coverage under the former plan ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

Your coverage ends, without notice from us, as provided below:

1. If the *policy* terminates, your coverage ends at the same time. The *policy* may be cancelled or changed without notice to you.

2. If the *group* no longer provides coverage for the class of *insured persons* to which you belong, your coverage ends on the effective date of that change. If this *policy* 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 the *employee's* coverage ends.

4. Coverage ends at the end of the period for which premium has been paid to us on your behalf when the required premium for the next period is not paid.

5. If you voluntarily cancel coverage at any time, coverage ends on the premium 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 COVERAGE BEGINS, your coverage ends as of the premium 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 an *insured employee* and the *group* pays premium 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 *insured employee*, *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 *insured employee* 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 *insured employee* must send proof of the *child's* physical or

mental condition within 60-days of the date the *insured employee* 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 *insured employee*, *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 *employee* 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 Blue Cross Life and Health suffers a loss because of the *employee* failing to notify the *group* of the termination of their marriage or

domestic partnership, Anthem Blue Cross Life and Health may seek recovery from the *employee* 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 *employee* 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 *employee'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.

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 *policy* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a period of 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 *policy* as either an *insured employee* or *insured family member;* and (b) a *child* who is born to or placed for adoption with the *insured employee* during the COBRA continuation period. Qualified Beneficiary does not include: (a) 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; or (b) a *domestic partner*, or a *child* of a *domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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

1. **For Insured Employees and Insured Family Members:**

    a. The *employee's* termination of employment, for any reason other than gross misconduct; or

    b. A reduction in the *employee's* work hours.

2. **For Retired Employees and their Insured Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided:

    a. The *policy* 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 Insured Family Members:**

    a. The death of the *insured employee;*

    b. The *spouse's* divorce or legal separation from the *employee;*

    c. The end of a *child's* status as a dependent *child,* as defined by the *policy;* or

    d. The *employee's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

An *insured employee* or *insured family member*, **other than a *domestic partner,* and a *child* of a *domestic partner***, may choose to continue coverage under the *policy* if his or her 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 *insured employee* or *insured 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 *employee* 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 *insured persons* within a family, or only for selected *insured persons*.

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 premium, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

Additional Insured 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 *policy* 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 "premium", must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the premium each month from the *group* in order to maintain the coverage in force.

Besides applying to the *insured employee,* the *employee's* premium rate will also apply to:

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

2. A *child*, if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the premium 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, an *insured person,* 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 *insured employee's* employment,

and was 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 premium 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 *policy*.

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 *insured employee,* divorce or legal separation, or the end of dependent *child* status;*
3. The end of 36 months from the date the *insured employee* became entitled to Medicare, if the Qualifying Event was the *employee'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 *insured employee* will end 36 months from the date the *insured employee* became entitled to Medicare;
4. The date the *policy* terminates;
5. The end of the period for which premiums are last paid;
6. The date, following the election of COBRA, the *insured person* 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 *insured person*, 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 *insured person* 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 an *insured person* 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 *policy* remaining in effect, a retired *employee* 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 *employee's* death. However, coverage could terminate prior to such time for either *employee* 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 member*s 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 *insured persons* 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 *insured person* 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 *insured person* 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 "premium") shall be subject to the following conditions:

1. If the disabled *insured person* continues coverage during this extension, this rate shall be **150%** of the applicable rate for the length of time the disabled *insured person* remains covered, depending upon the number of covered dependents. If the disabled *insured person* 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 premium 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 premium rate shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *insured person* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *insured person* 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 *policy* terminates;

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

5. The date, following the election of COBRA, the *insured person* first becomes covered under the other group health plan, unless the other group health plan contains an exclusion or limitation to a pre-existing condition of the *insured person*, 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 *insured person* 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 INSURED PERSONS

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of premium as stated in the *policy,* coverage under this *plan* may be continued for the *insured employee,* the *insured employee's spouse,* and the *insured employee's* former *spouse* (if any) under Section 10116.5 of the Insurance 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 *insured employee;* or (b) an individual who was married to the *insured employee* at the time of the *insured employee's* death.

Requirements. The *insured employee* and *spouse* may continue coverage under this *plan* if:

1. The *employee,* or the *employee* 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 *employee* or *spouse* has not elected to continue coverage under any other available continuation;

3. The *employee* has worked for the employer for at least the prior five years; and

4. The *employee* 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 *insured employee* 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 *employee* and *spouse*, this continuation may be chosen for both, for the *employee* 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 premium 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 premium 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 premiums payable, the *spouse* or former spouse continuing coverage alone will be considered to be an *employee*.

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 premiums are due on the first day of each following month (the Premium Due Date).

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

Premium Rate Change. The premium rates may be changed by us as of any Premium Due Date. We will provide you with written notice at least 30 days prior to the date any premium rate 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 premiums are last paid;

2. The date the *policy* terminates;

3. The date, following the election of Senior COBRA, the *insured employee, 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 *employee, spouse,* or former *spouse* first becomes entitled to Medicare;

5. The date the *employee, 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 *employee* dies while covered under this *plan*, coverage continues for enrolled *family members* until one of the following occurs:

1. The surviving spouse remarries;

2. Premium is not paid to us on the *insured person's* behalf;

3. The *group* cancels coverage for the class of *employees* to which the *insured person* belongs;

4. The *policy* 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 *insured person* may be responsible for all or part of the premium.

EXTENSION OF BENEFITS

If you are a *totally disabled employee* or a *totally disabled family member* and under the treatment of a *dentist* on the date of discontinuance of the *policy*, 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 responsible for providing any type of dental care, nor are we responsible for the quality of such care received.

Independent Contractors. Our relationship with providers is that of an independent contractor. *Dentists and* other dental health professionals are not our agents nor are we or any of our employees, an employee or agent of any dental group or dental care provider of any type.

Non-Regulation of Providers. The benefits provided under this *plan* do not regulate the amounts charged by providers of dental care, except to the extent that rates for covered services are regulated with *participating dentists*.

Terms of Coverage

1. In order for you to be entitled to benefits under the *policy*, both the *policy* and your coverage under the *policy* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The *policy* is subject to amendment, modification or termination according to the provisions of the *policy* 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 in effect; (2) you are eligible; and (3) your premiums are paid according to the terms of the *policy*.

Free Choice of Provider. You may choose any dental care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

Medically Necessary. The benefits of this *plan* are provided only for services which are *medically necessary*. The services must be ordered by the attending *dentist* for the direct care and treatment of a covered condition. They must be standard dental practice where received for the condition being treated and must be legal in the United States.

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 *insured persons* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You, or someone on your behalf, must give us written notice of a claim within 20 days after you incur *covered expense* under this plan, or as soon as reasonably possible thereafter.

Claim Forms. After we receive a written notice of claim, we will give you any forms you need to file proof of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you will not have to use these forms, and you may file proof of loss by sending us written proof of the occurrence giving rise to the claim. Such written proof must include the extent and character of the loss.

Proof of Loss. You or the provider of service must send us properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

Timely Payment of Claims. Any benefits due under this *plan* shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

Payment to Providers. We will pay the benefits of this *plan* directly to *participating dentists*. Also, we will pay *non-participating dentists* directly when you assign benefits in writing. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. When the amount we paid exceeds our liability under this *plan*, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

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.

Workers' Compensation Insurance. The *policy* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Entire Contract. This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire *policy* which includes this certificate. The terms of the *policy* may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the *policy*.

Liability For Statements. No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the *policy*. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

Physical Examination. At our expense, we have the right and opportunity to examine any *insured person* claiming benefits when and as often as reasonably necessary while a claim is pending.

Legal Actions. No attempt to recover on the *plan* through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this *plan*. No such action may be started later than three years from the time written proof of loss is required to be furnished.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, we will provide benefits at the *participating dentist* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a *dentist* at the time we terminate our contractual relationship with the *dentist* (unless the *dentist's* contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a *dentist* who voluntarily terminates his or her contract.

You must be under the care of the *participating dentist* at the time the *dentist's* contract terminates. The terminated *dentist* must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with us prior to termination. The *dentist* must also agree in writing to accept the terms and reimbursement rates under his or her agreement with us prior to termination. If the *dentist* does not agree with these contractual terms and conditions, we are not required to continue the *dentist's* services beyond the contract termination date.

We will provide such benefits for the completion of covered services by a terminated *dentist* 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 *dentist*, as determined by us in consultation with you and the terminated *dentist* and consistent with good professional practice. Completion of covered services shall not

exceed twelve (12) months from the date the *dentist'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 *dentist'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 *dentist* to occur within 180 days of the date the *dentist's* contract terminates.

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 your 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 *dentist* 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 *dentist's* are negotiated on a case-by-case basis. We will request that the terminated *dentist* agree to accept reimbursement and contractual requirements that apply to *participating dentists*, including payment terms. If the terminated *dentist* does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that *dentist's* services. If you disagree with our determination regarding continuity of care, you may file a complaint with us as described in the COMPLAINT NOTICE.

INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT

If coverage for a proposed treatment is denied because we 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 California Department of Insurance ("CDI"). Your request for this review may be submitted to the CDI. 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. We will send you 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 Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367. 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 *dentist* 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 qualified *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 are not required to go through our grievance process for more than 30 days. If your grievance needs expedited review, you are not required to go through our grievance process for more than three days.

You must request this review within six months of the date you receive a denial notice from us 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 CDI for good cause.

Within three business days of receiving notice from the CDI 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 *dentist*. 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 *dentist* 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.

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 California Department of Insurance (“CDI”) if you believe that we 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, 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 CDI will review your application for IMR to confirm that:

1. (a) Your *dentist* has recommended a health care service as *medically necessary*, or

   (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, 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 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 CDI 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 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 CDI 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 benefits for the health care service.

For non-urgent cases, the IMR organization designated by the CDI 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.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or the *policy*, 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 *insured person* and Anthem Blue Cross Life and Health 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.

The *insured person* and Anthem Blue Cross Life and Health 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 *insured person* waives any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health waives any right to pursue on a class basis any such controversy or claim against the *insured person*.

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 *insured person* making written demand on Anthem Blue Cross Life and Health. 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 *insured person* and

Anthem Blue Cross Life and Health, or by order of the court, if the *insured person* and Anthem Blue Cross Life and Health 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 Blue Cross Life and Health will assume all or a portion of the costs of the arbitration.

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

DEFINITIONS

The meanings of key terms used in this certificate 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 your certificate, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) is the company which insures the benefits of the *plan*.

Child meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

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 rules for 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*).

Covered dental expense (covered expense) is the expense you incur for a covered service or supply, but not more than the maximum amounts described in items 1 and 2 below. Expense is incurred on the date you receive the service or supply. Covered dental expense does not include:

1. For all *participating dentists*, any charge in excess of the *dental negotiated rate;* or

2. For *non-participating dentists*, any charge in excess of the amount determined as follows:

    a. We purchase dental claims data from an independent and reliable third party vendor that gathers such data as a regular part of their business. The data shows us what a majority of *dentists* charge in various geographic areas in the United States for each dental service.

    b. Using the data, described above in a., for each geographic area determined by us and each service, we calculate an amount that reasonably will result in the charge submitted by a majority of *dentists* in a geographic area for a particular service being considered fully eligible for use in the benefit calculation process; and

    c. We set the maximum covered expense at the amount calculated above in b.

The third party data described above is subject to periodic review and update as deemed appropriate, but not less than once a *year*.

Dental negotiated rate is the amount *participating dentists* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Dental negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements.

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 HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Early-retired employee is a former full-time employee who meets the eligibility requirements outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Effective date is the date your coverage begins under this *plan*.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Full-time employee meets the *plan's* eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.

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

Insured employee (employee) is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *family members*.

Insured family member (family member) meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

Insured person is the *insured employee* or *insured family member*.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Medically Necessary procedures, services or supplies are those which are:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the dental condition;

2. Customarily provided for the prevention, diagnosis, or direct care and treatment of the dental condition;

3. Within standards of good dental practice within the organized dental community;

4. Not primarily for your convenience, or the convenience of your *dentist* or another provider; and

5. Based on prevailing dental practices, the least expensive covered service suitable for your dental condition which will produce a professionally satisfactory result.

Non-participating dentist is a *dentist* which does NOT have a Prudent Buyer Plan Participating Provider Agreement with us at the time services are rendered.

Participating dentist is a *dentist* which has a Prudent Buyer Plan Participating Agreement in effect with us at the time services are rendered. *Participating dentists* agree to accept the *dental negotiated rate* as payment for covered services. A directory of participating dentists is available upon request.

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 *policy* 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 *employee* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Policy is the Group Policy we have issued to the *group*.

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.

Spouse meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Totally disabled employee is an *employee* who, because of 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.

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

We (us, our) refers to Anthem Blue Cross Life and Health Insurance Company.

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 *insured employee* and *insured family members* who are enrolled for benefits under this *plan*.