Pacific Union Dental, Inc.

DENTAL PLAN

Evidence of Coverage

ISSUED BY

Pacific Union Dental, Inc.

PACIFIC UNION DENTAL℠

A Dental Benefit Providers of California, Inc. Product.

Please retain this booklet. It contains important information about your PACIFIC UNION DENTAL, INC. Plan.

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PACIFIC UNION DENTAL, INC.

2300 CLAYTON ROAD, SUITE 1000

CONCORD, CA 94520

1-800-999-3367

FAX # 1-925-363-6099

Pacific Union Dental, Inc.

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

A specimen copy of the Group Subscriber Benefit Agreement will be furnished to you upon request. Any questions you have concerning the Group Subscriber Benefit Agreement or its coverage should be addressed to your Organization, or if you prefer, you may direct your inquiry to:

PACIFIC UNION DENTAL, INC.

2300 CLAYTON ROAD, SUITE 1000

CONCORD, CA 94520

1-800-999-3367

PACIFIC UNION DENTAL, INC. (hereinafter referred to as "Company") agrees to furnish benefits to you and your eligible dependents, subject to the terms and conditions of the Group Subscriber Benefit Agreement issued to your Organization.

HOW TO USE YOUR PLAN

General Dental Services: Please select a dental office from the list of contracted Plan Providers and indicate the dental office and ID# on the enrollment form. The Plan will assist you in selecting a dentist whenever you request such assistance. Thereafter, to obtain services, you need only to contact the selected dental office and make an appointment. In the event you are dissatisfied with the dental office you selected, for any reason, and desire to transfer to another, you may do so by contacting the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

Specialty Services: Should your treatment plan require the services of a specialist your Plan Provider will refer you. All benefits and copayments apply to specialty services, provided the referral has the prior approval of the Plan's Dental Director. If you need assistance with obtaining a specialty referral, please contact the Customer Service department listed below.

Emergency Services or Urgent Care: Should you need urgent care or are experiencing a dental emergency, please contact your Plan Provider and indicate that you are in need of urgent or emergency care. If you need assistance with obtaining emergency or urgent care from your Provider, or if you are out of the area, you may contact the Customer Service Department at 1-800-999-3367 during normal business hours to arrange for out-of-area emergency care.

After Hours Care: If you need services after hours, first contact your assigned Plan Provider. Plan Providers are required to have 24-hour access to on-call care. If you are unable to contact your dental office, this plan provides for reimbursement for any emergency after-hours care out of the area up to $100, less any usual copayments required for any procedures performed on a fee-for-service basis. If you need such care after-hours, you must notify the Plan within 48 hours of receiving care from a non-participating provider.

Out-of-Area Care: To receive dental care out of your area, first contact Customer Service at 1-800-999-3367 to determine if you can be served by another contracted Plan Provider. If you live more than 50 miles from a contracted Plan Provider, you may be directed to seek care from a non-Plan provider. If you need services after-hours, please refer to the above after hours care section.

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Additional Information regarding your plan benefits may be obtained by calling the Company offices at 1-800-999-3367.

SECTION I - DEFINITIONS:

1.1 "Aesthetic Dentistry" means any dental procedures, which are performed for cosmetic purposes and where there is limited restorative value.

1.2 "Benefit Agreement" means the written agreement entered into between Company and groups, organizations or individuals, under which Company provides, indemnifies or administers dental benefits to persons, groups or organizations.

1.3 "Benefits and Coverage" means the dental care services available under the Group Subscriber Benefit Agreement in which a member is enrolled.

1.4 "Company" means PACIFIC UNION DENTAL, INC.

1.5 "Copayment" means an additional fee charged to a member, which is approved by the Commissioner of Corporations, provided for in the Group Subscriber Benefit Agreement and disclosed in the Evidence of Coverage or the Disclosure Form used as the Evidence of Coverage.

1.6 "Contract" means the agreement between Organization and Company.

1.7 "Covered Dental Services" means the dental care services available under the Group Subscriber Benefit Agreement in which a member is enrolled.

1.8 "Dental Director" means a California licensed dentist who is contracted or employed by Company to provide professional advice concerning the operation of the Group Subscriber Benefit Agreement.

1.9 "Dentist" means an individual who is licensed as a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) in accordance with applicable California State Laws and is practicing within the scope of such license including any hygienists and technicians recognized by the dental profession who act and assist the dentist.

1.10 "Dependent" means the spouse and children, if enrolled in the Company, of a member and shall include all newborn infants whose coverage shall commence from and after the moment of birth. Adopted children, stepchildren and foster children are covered from and after the legally certified date of placement. Children are also subject to the applicable age limitations as established by each group or organization and any additional requirements in accordance with the Group Subscriber Benefit Agreement.

1.11 "Elective Dentistry" means any dental procedures, which are unnecessary to the dental health of the patient, as determined by a Plan Dentist.

1.12 "Eligible Participants" means employees, members, dependents or beneficiaries of Organization who are eligible to participate in the plan under the eligibility requirements set forth by Organization.

1.13 "Emergency" means a condition in which the member has severe pain or symptoms that, if not treated immediately, would lead to unnecessary suffering, disability or death.

1.14 "Emergency Services" means services required for alleviation of severe pain or symptoms which, if not treated immediately, would lead to unnecessary suffering, disability or death.

1.15 "Exception" means any variance with the provisions of the Group Subscriber Benefit Agreement.

1.16 “Exclusion” means any provision of the Group Subscriber Benefit Agreement whereby coverage for a specified hazard or condition is entirely eliminated.

1.17 “General Practitioner” means a dentist who practices general dentistry and does not hold himself/herself out to be a specialist in a particular field of dentistry.

1.18 “Group Subscriber Benefit Agreement” means the written agreement entered into between Company and groups, organizations or individuals, under which Company provides, indemnifies or administers dental benefits to persons, groups or organizations.

1.19 “Limitation” means any provision other than an exclusion, which restricts coverage under the Group Subscriber Benefit Agreement.

1.20 “Member” means a person who is actually enrolled in Company and eligible to receive services as provided for herein under a health plan provided by Company. The term "member" or "members" shall be deemed to include all eligible dependents of a member as defined herein, if so enrolled in a health plan provided by Company.

1.21 “Non-Participating Provider” means any duly-licensed Doctor of Dental Surgery, Doctor of Medical Dentistry or dental professional corporation, who has not signed a contract to provide dental services for the Company.

1.22 “Organization” means an organized group or body of members, eligible participants, and/or others that have entered into a Group Subscriber Benefit Agreement with the Company.

1.23 “Peer Review Committee” means regional committees composed of dentists pursuant to the requirements of the State of California's Department of Managed Health Care.

1.24 “Plan” means benefits and coverages and other charges as set forth herein.

1.25 “Plan Dentist” means the professional provider under contract with the Company.

1.26 “Plan Provider” means the professional provider under contract with the Company.

1.27 “Prepayment Fee” means the amount payable each month on a prepayment basis by a member of the Organization (or both) to obtain benefits provided under the Group Subscriber Benefit Agreement.

1.28 “Prevailing Rates” means the usual, customary and reasonable charges prevailing in the geographic area in which the professional provider's office is located; a copy of such charges are to be kept at the professional provider's office.

1.29 “Principal Benefits and Coverage with Copayments” means those benefits and coverages for which the member has a copayment.

1.30 “Principal Benefits and Coverage without Copayments” means those benefits and coverages for which the member has no copayment.

1.31 “Principal Excluded Procedures and Services” means those services which are specifically not benefits and coverage.

1.32 “Principal Limitations” means those benefits and coverage, which are limited in frequency, number or scope of treatment.

1.33 “Professional Provider” means the dentist under contract with Company.

1.34 “Public Policy Committee” means an advisory committee composed of dentists, members and members of Company’s Board of Directors pursuant to the requirements of the State of California's Department of Managed Health Care.

1.35 “Quality Assurance” means the bonafide formal confidential review program of the facilities, treatment methods, treatment results and individual members’ treatment records for each professional provider.

1.36 “Service Area” means a geographical area designated by the Company within which the Company shall provide services.

1.37 “Special Notice” means communication requiring time deadline compliance by either party to the Group Subscriber Benefit Agreement sent by Certified Mail, Return Receipt Requested.

1.38 “Specialist” means a dentist who is responsible for the specific specialized dental care of a plan member in one specific field of dentistry such as endodontics, periodontics, oral surgery or orthodontics where the member is referred by a professional provider affiliated with the Company.

1.39 “Specialty Referral Guidelines” means specific procedures to be followed for benefits and coverage provided by dentists other than the dentist.

1.40 “Specific Specialized Dental Care” means a treatment plan (dental care) diagnosed and administered to a particular patient, which a patient receives as a result of the referral to a specialist by the professional provider affiliated with the Company.

1.41 “Subscriber” means any groups, organizations or individuals that agree by the Group Subscriber Benefit Agreement to pay for and receive dental benefits and coverage from the COMPANY.

1.42 “Terminated Provider”means a licensed Plan Provider who formerly delivered Covered Services under a contract with the COMPANY, but who is no longer associated with the COMPANY.

SECTION II - PRINCIPAL BENEFITS AND SERVICES:

2.1 Subject to the following terms and conditions contained herein, benefits outlined in the enclosed Benefit Schedule (located in the back of this booklet) are available to plan members. All benefits outlined in the Evidence of Coverage must be obtained from a Plan Provider. The schedule establishes the covered dental services, which are available without charge, designated as "No Charge" in the schedule and those services for which members are obligated to pay the Plan Provider. The amount of the, copayment which the Plan Provider is permitted to charge for specific dental services, is set forth under the heading “Member’s Copayment”. The benefits and services are available from the Plan Provider with copayments where indicated.

2.2 PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. The Company contracts with general and specialized dentists to provide quality dental services for eligible group members. You must select and seek all dental services from a Plan Provider listed in the Company provider directory. The Company compensates its’ providers using direct reimbursement, discounted fee for service, fee for service and capitation. The dentist also receives compensation from Company enrollees who pay a defined “copayment” for specific dental services. In addition, there may be occasions when a program may provide supplemental payments for specific dental procedures. These are the only forms of compensation the general dentist receives from the Company and the schedule of copayments is located inside this Evidence of Coverage and Disclosure Form. The Company does not use provider incentives or bonus plans to influence specific dental care decisions.

SECTION III - EMERGENCY PROCEDURES:

3.1 The Company is responsible for providing emergency dental services to you immediately upon enrollment in our dental plan. Emergency services are subject to the limitations and exclusions set forth below.

3.1-1 In the event of an out-of-area emergency, you should contact the Company at 1-800-999-3367. The Company will direct you to an available Plan Provider. Should no Plan Provider be available within a 50-mile radius, you will be advised to seek treatment from a non-Plan Provider. However, should it prove impossible for you to advise the Company, emergency services rendered by a non-Plan Provider will be covered if notice is given to the Company within forty-eight (48) hours after the service was provided. The Company will reimburse you for the cost of such services up to a maximum of $100.00 per calendar year, less any usual copayment required for the procedure performed on a fee-for-service basis.

3.1-2 The Company has a written policy describing how the Company facilitates the continuity of care for new enrollees receiving services during a current episode of care for an acute condition from a non-participating provider. Eligible enrollees may request a copy of the Company's written policy, which includes information on how enrollees may request a review under the policy.

3.2 You must submit a claim form when requesting reimbursement. Necessary forms are available at the Company administrative office. A claim for payment must be made within ninety (90) days after the services were rendered.

3.3 All claims will be acted upon within twenty (20) days after receipt by the Company unless additional information is required. Upon receipt by the Company of such additional required information, the claim will be granted or denied, either partially or completely, within forty-five (45) days. If the claim is partially denied, you will receive written notification of the decision. This notification will include the specific reasons for which the denial is based and that you may request reconsideration of the denial by filing a written notice with the Company within one (1) year after receiving notification of the denial. Reconsideration will be made by the Grievance Committee and the decision of said Committee shall constitute a final determination of the claim.

SECTION IV - PLAN MEMBER IDENTIFICATION:

4.1 The Company shall make available the benefits outlined in the Benefit Schedule to those persons who are members.

4.2 The Organization shall determine and provide the member with the effective times, dates and any applicable waiting periods(s) for the occurrence upon which coverage takes effect.

4.3 The Company shall furnish you an identification card evidencing enrollment.

4.3-1 Cards issued by the Company to you are for identification only. Possession of a Company Identification Card confers no rights to services or other benefits. To be entitled to such services or benefits, you must, in fact, be a member on whose behalf all applicable fees have actually been paid. Any services or other benefits received to which you are not then entitled will be charged at prevailing rates.

4.3-2 If any member permits the use of his Company Identification Card by any other person, such card may be retained by the Company and all rights of such member pursuant to the Group Subscriber Benefit Agreement shall be immediately terminable at the will of the Company.

SECTION V - TERMINATION OF BENEFITS:

5.1 If Plan Provider, after reasonable efforts to establish and maintain a satisfactory provider-patient relationship with any member, is unable to do so, then the rights of the member may be terminated on not less than thirty (30) days written notice to the member.

5.2 If a member fails to pay any amount due the Company or Plan Providers within thirty (30) days after notice to the member of the amount due, then the Company may terminate the rights of the member and the member's dependents effective immediately upon written notice and the rights may be reinstated only by payment of the amounts due and by renewed application and re-enrollment. Services received after the effective date of termination are charged at prevailing rates.

5.3 The determination of any member termination, relative to the rules and regulations of the Organization, shall be decided by the Organization and the Company shall have the right to rely upon that determination. Any disputes or inquiries regarding such a termination shall be referred by the Company to the Organization, which shall then advise the Company of its determination. The time and the date or occurrence upon which benefits and coverage will terminate will be determined in such a termination by the Organization.

5.4 A spouse who is enrolled in the Company who ceases to be a qualified family member by reason of termination of marriage or death of the member will be afforded certain conversion rights and conditions as described within the Organization's Group Subscriber Benefit Agreement.

5.5 A member who alleges that a subscription has been terminated or not renewed because of the member's dental health status or requirements for dental health care services may request a review of cancellation by the Commissioner of the Department of Managed Health Care.

SECTION VI - REINSTATEMENT OF MEMBER AND INDIVIDUAL CONTINUATION OF BENEFITS:

6.1 INDIVIDUAL CONTINUATION OF BENEFITS

A. Loss of Group Eligibility

Any member who becomes ineligible for group coverage may apply within thirty (30) days of notice of ineligibility to continue plan coverage. The terms and conditions under the Group Subscriber Benefit Agreement in which such member was enrolled shall continue in effect with the following exceptions: Notices and distribution of materials as required for the member will be delivered directly to the Organization; member shall pay the applicable monthly premium in effect at the time the application to continue coverage is approved by the Organization. Such extension of coverage shall apply to the dependent(s) of the converting members upon the same terms and conditions as applied to the converting member. Such application may be accepted or rejected at the option of the Company; no automatic right of individual continuation of benefits exist.

B. Conversion Upon Death or Divorce of a Member

A spouse who is enrolled in the Company who ceases to be a qualified family member by reason of termination of marriage or death of the member will be afforded to same conversion rights and conditions granted to the member under paragraph A of this section.

C. Loss of Eligibility Due to Termination of Group Subscriber Benefit Agreement

The Company reserves the right to offer conversion privileges to the member who becomes ineligible due to the termination of the Group Subscriber Benefit Agreement. Should such

conversion be offered to the member, application must be made within thirty (30) days of notice of ineligibility to continue plan coverage. The terms and conditions under the Group Subscriber Benefit Agreement in which such member was enrolled shall continue in effect with the following exceptions: Notices and distribution of materials as required will be delivered directly to the member; member shall pay the applicable monthly premiums in effect at the time the application to continue coverage is approved by the Company. Such extension of coverage shall apply to the dependent(s) of the converting member upon the same terms and conditions as applied to the converting member.

SECTION VII - BINDING ARBITRATION:

7.1 Any controversy or dispute between interested parties (which term includes the Organization, a member, a dependent, or the heirs-at-law or personal representatives of a member or dependent and Company, its agents, professional providers, or employees), whether involving a claim in tort, contract or otherwise and including disputes which are not adequately resolved by the Company's grievance procedures, shall be submitted to binding arbitration. If the matter in dispute is one that is subject to review under the Company's grievance procedures, arbitration may not be initiated until completion of such procedures. All claims, controversies and disputes shall be submitted to the National Arbitration Forum in accordance with its Health Care Claim Settlement Procedures. Judgment on the award rendered by the arbitrator may be duly entered in any court in the State of California having jurisdiction thereof. Such arbitration may be initiated by any interested party by contacting the National Arbitration Forum. In cases of extreme hardship, the Company shall assume all or a portion of a member's share of the fees and expenses of the neutral arbitrator. A member may request information on how to obtain an application for relieve in cases of extreme hardship by contacting either the Company's Customer Service Department at 1-800-999-3367 or the National Arbitration Forum. The prevailing party shall be entitled to court costs and reasonable attorney's fees.

SECTION VIII - REPORTS AND RECORDS:

8.1 The member agrees that the Organization may make available to the Company such employment records, which have a bearing upon the eligibility of the subscriber or member.

SECTION IX - MISCELLANEOUS PROVISIONS:

9.1 Application, Statements, Etc.

Member(s) or those persons applying for membership shall complete and submit to the Company such applications, forms or statements as the Company may reasonably request. Member(s) represent(s) that all information contained in such applications, questionnaires, forms or statements submitted to the administration hereof are not knowingly untrue, incorrect and incomplete and all rights to benefits hereunder are subject to the condition that all such information is true, correct and complete.

9.2 Liability of the Plan

Members may be liable to pay non-contracting providers, where the member has not been referred to said non-contracting provider by his Plan Provider. In the event a provider fails to pay a specialist for services rendered to an enrollee referred by said provider to said specialist, the Company shall be liable to the specialist, less any usual member copayment(s).

9.3 Relations Among Parties

Plan Providers maintain the dentist-patient relationship with members and are solely responsible to members for all dental services. Information from dental records of members and information received by Plan Providers incidental to the provider-patient relationship is kept confidential and except for use incidental to bonafide medical or dental research or quality assurance and unless reasonably necessary in connection with the administration of the contract, including Medicare requirements, is not disclosed without the consent of the member. Access to all such information; however, will be granted to the State of California Department of Managed Health Care.

9.4 Grievance Procedures

Members are encouraged to contact the Company regarding any problems that are encountered while obtaining services. The Company maintains a Grievance Management System for the receipt, handling and disposition of member complaints. Member complaints or grievances can be made in person at the Company offices or can be made in writing. Members may also file a grievance online at **www.myuhcspecialtybenefits.com**. Complaint forms may be obtained from and should be returned to the Company office located Mailstop CA152-0293, P.O. Box 25187, Santa Ana, CA 92799-5187 **1-800-999-3367**. Members will receive a written response of the disposition and/or pending status of the complaint within thirty (30) days of an appeal. If the member is not satisfied with treatment received from a Plan Provider, a proposed treatment plan, denial of treatment or has concerns or questions about treatment that cannot be addressed by the member's assigned provider and/or the Company's Dental Director, the member may request a second opinion from a Company contracted general dentist or specialist. There is no cost for a second opinion from a Company contracted general dentist or specialist, except for applicable copayments, if any. The request for a second opinion is reviewed by the Company's Dental Director or Dental Consultant. A second opinion must be arranged through the Company's Customer Service Department by calling 1-800-999-3367.

Required Statement: "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-999-3367** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online."

The Company does not discriminate or tolerate discrimination of any kind against an enrollee who has filed a complaint with the Company of any kind (i.e. against a provider or the Company itself, or any other complaint). No Plan contract shall be cancelled because an enrollee filed a complaint with the Company.

9.5 Governing Law

The Company is subject to the requirements of the Knox Keene Act and any provision required to be in this Evidence of Coverage or the Group Subscriber Benefit Agreement shall bind the Company whether or not set forth herein.

9.6 Termination of a Provider

In the event that a Plan Provider contract is terminated, the Company will be liable for covered services rendered by such Plan Provider to member under the Company Group Subscriber Benefit Agreement or by operation of law for care provided at the time of the termination until the services being rendered are completed. The Company reserves the option to make reasonable and medically appropriate provisions for the assumption of such services by another Plan Provider.

9.7 Continuation of Covered Services

Current Members:

Current Members may have the right to the benefit of completion of care with their Terminated Provider (as defined in Section I of this Evidence of Coverage and Disclosure Form) for certain specified dental conditions. Members should call the Company at **1-800-999-3367** to see if they may be eligible for this benefit. Members may request a copy of the Company's Continuity of Care Policy. Members must make a specific request to continue under the care of their Terminated Provider. The Company is not required to continue a Member's care with that Terminated Provider if the Member is not eligible under the Company's policy or if the Company cannot reach agreement with the Member's Terminated Provider on the terms regarding the Member's care in accordance with California law.

New Members:

A new Member may have the right to the qualified benefit of completion of care with their Non-Participating Dentist (as defined in Section I of this Evidence of Coverage and Disclosure Form) for certain specified dental conditions. Members may call the Plan at **1-800-999-3367** to see if they may be eligible for this benefit. Members may request a copy of the Company's Continuity of Care Policy. Members must make a specific request to continue under the care of their current non-Participating Dentist. The Company is not required to continue a Member's care with that non-Participating Dentist if the Member is not eligible under the Company's policy or if the Company cannot reach agreement with the Member's Non-Participating Dentist on the terms regarding the Member's care in accordance with California law. This policy does not apply to new Members of an individual subscriber contract.

SECTION X - COORDINATION OF BENEFITS (COB):

10.1 If an eligible member is entitled to benefits and coverage under other group insurance policies, then the benefits of this plan shall be provided as follows:

10.1-1 A plan which does not contain a C.O.B. provision must release its benefits first, ahead of a plan which does contain such a provision.

10.1-2 A plan which covers the patient as an insured must release its benefits first, ahead of a plan which covers the patient as a dependent.

10.1-3 A plan which covers the patient as a dependent, the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan which covered the other parent for a shorter time pays second. A person's year of birth is not relevant in applying this rule.

10.1-4 In situations where parents of the dependent member are separated or divorced, the following rules establish the order that benefits will be released:

1) A plan that covers the member as a dependent of the parent with custody pays first;

2) If the parent with custody remarries, the plan that covers the member as a dependent of the stepparent pays second; and

3) The plan that covers the member as dependent of the parent without custody pays third.

Exception: Notwithstanding the above, if a court decree establishes financial responsibility for dental care with respect to the dependent member, then the plan that covers the member as a dependent of the parent with financial responsibility pays first before any other plan which covers the member as a dependent.

10.1-5 The plan which has covered the patient for the longer period of time will release its benefits first. In determining the length of time an individual has been covered the following rules apply: a) two successive plans of a given group should be regarded as one continuous plan as long as the patient was eligible under the new plan within twenty-four (24) hours after coverage under the prior plan terminated; b) if the patients individual effective date of coverage is subsequent to the group policy's effective date, measure the length of time from the patient's individual effective date; c) if the patient's individual effective date is the same as the group policy's effective date, request the group's administrator to furnish the date coverage first became effective under the earliest of any previous plans the group may have had. If that date is not readily available, the date the patient first became a member of the group shall be used as the date from which to determine the length of time he has been covered by the plan.

10.1-6 If the plan of benefits provided by this program is primary as provided above, the other policies or plan shall provide benefits to the extent possible to provide all payment of any included copayments and if the other policy(ies) or plan(s) is (are) primary, the other plan or policy shall provide benefits to the maximum extent possible. If those benefits provided by the other policies or plans exceed or equal any included copayments, the copayments will be reduced to the extent of benefits provided by the other plan or policies.

10.1-7 Whether the other coverage is a group or non-group prepaid program, the member may obtain covered services from a participating Plan Provider on either plan, not both, and is subject to the appropriate copayments.

10.1-8 If the Plan Provider is a participating dentist for both prepaid plans, s/he will charge the lesser of the two plans' copayments applicable to the services rendered.

10.1-9 If the other coverage is a group insurance program, the Plan Provider will provide covered services to the member at the copayments specified in the Company Copayment Schedule and shall submit for insurance claims the amounts of the copayments specified in the Company Copayment Schedule and not his or her usual and customary fees.

10.1-10 If the other coverage is a non-group insurance program, the Plan Provider may use his or her usual and customary fees for submitting insurance claims, but he or she may not collect more, from both the insurance payments and the member payments combined, than the copayments specified in the plan of benefits. The member may not accept any insurance payment in excess of the copayment for a specified covered service.

10.2 For the purposes of determining the applicability of and implementing the terms of this provision of this plan or any provision of similar purpose of any other plan, the Company may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Company deems necessary for such purposes. Any person claiming

benefits under this plan shall furnish such information as may be necessary to implement this provision.

SECTION XI - ELIGIBILITY:

11.1 The determination of who is eligible to participate and who is actually participating in the Company shall be decided by Organization, as set forth in the rules and regulations of the Organization, and the Company shall have the right to rely on that determination. Any disputes or inquiries regarding eligibility, including rights regarding renewal, reinstatement and the like, if any, shall be referred by the Company to Organization, which shall then advise the Company of its determination.

11.2 Subject to all of the above eligibility requirements, the Company guarantees the following:

11.2-1 Dependents shall include member's spouse, all newborn infants whose coverage shall commence from the moment of birth and all adopted, foster and step children whose coverage shall commence from the date of placement.

11.2-2 Dependents shall include all children under the age of 26 years.

11.2-3 Unmarried enrolled Dependents who attain the limiting age established by the Group may continue enrollment in the Plan beyond the limiting age if the unmarried Dependent meets all of the following:

A. The unmarried Dependent resides within the Service Area with the Subscriber, the Subscriber's separated or divorced spouse or the terminated domestic partner;

B. The unmarried Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition;

C. The unmarried Dependent is chiefly dependent upon the Subscriber for support and maintenance; and

D. The mental or physical condition existed continuously prior to reaching the limiting age.

At least 90 days prior to a disabled Dependent reaching the limiting age, the Company will send notice to the Subscriber that coverage for the disabled Dependent will terminate at the end of the limiting age, unless proof of such incapacity and dependency is provided to the Company by the Member within 60 days of receipt of notice. The Company shall determine if the disabled Dependent meets the conditions above, prior to the disabled dependent reaching the limiting age. Otherwise, coverage will continue until the Company makes a determination.

The Company may require ongoing proof of a Dependent's disability and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the limiting age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of physical or mental disabling injury, illness or condition.

If the Subscriber is enrolling a disabled child for new coverage, the Company may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. The Subscriber must provide the Company with the requested information within 60 days of receipt of the request. The child must have

been covered as a Dependent of the Subscriber or spouse under a previous health plan at the time the child reached the age limit.

11.2-4 Should a member be terminated or become ineligible for benefits, that member shall continue to be eligible to receive services and Company shall be entitled to its monthly fee for that member until such time as the Organization notifies the Company in writing of the member's termination or loss of eligibility and the member is removed from the eligibility list. Should Company be notified of a member's termination or loss of benefits after the eligibility list is provided or after the first of the month, coverage for that member shall continue until the end of the month and Company shall retain or must be paid its monthly fee for that member to the end of the month.

SECTION XII - PUBLIC POLICY COMMITTEE:

12.1 The Company has established a Public Policy Committee consisting of representatives of the Company, Plan Providers and Subscriber Groups to provide input to the Company regarding services and benefits and to participate in policy-making decisions. If you would like more information about the role of the committee and your opportunity to participate in it, please contact your group representative or the Company business office.

SECTION XIII - CALIFORNIA REGULATION NOTICES:

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

SECTION XIV - EXCLUDED PROCEDURES AND SERVICES:

14.1 The following dental procedures and services are not included in the plan:

14.1-1 General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation and prescription drugs.

14.1-2 Dental conditions arising out of and due to enrollee’s employment or for which Worker’s Compensation is payable, or any other third-party is liable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, county or other subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.

14.1-3 Benefits do not include splinting, hemisection, implants, overdentures, grafting (unless otherwise stated), guided tissue regeneration, all-ceramic cast restorations, precision attachments, duplicate dentures, and appliances for the treatment of bruxism.

14.1-4 Dental services and any related fees performed in a treatment facility other than the contracted provider’s office (i.e. hospital, ambulatory care facility, outpatient clinic, surgical center, etc.).

14.1-5 Treatment of fractures and dislocations of the jaws.

14.1-6 Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures) regardless of payor.

14.1-7 Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress prior to Member's eligibility with DBP-CA (e.g.: teeth prepared for crowns, root canals in progress, fixed and removable prosthetics). Crowns, bridges or dentures started in one office (while under DBP-CA coverage) are considered "in progress" until delivered. Additional benefits will not be provided for such treatment in progress.

14.1-8 The Schedule of Benefits of procedures is the definitive statement of coverage, and supersedes all other materials. Any service that is not specifically listed as a covered benefit is excluded from coverage, regardless of any other written material presented or implied.

14.1-9 Procedures, appliances or restorations to correct congenitally and/or developmentally missing teeth or other congenital and/or developmental conditions, developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, anodontia) and supernumerary teeth.

14.1-10 Treatment/removal of malignancies, cysts, tumors or neoplasms.

14.1-11 Dispensing of drugs not associated with a course of dental care, such as medicinal irrigation, locally administered antibiotics and prescription drugs.

14.1-12 Crowns, bridges and/or dentures placed as a definitive restoration of tooth structure lost as a result of accidental injury. Accidental injury is defined as damage to the hard or soft tissues of the oral cavity resulting from external forces to the mouth. Treatment for all accident-related services payable by another liability carrier, other than a dental plan. (NOTE: "Definitive" refers to a "final" or "permanent" appliance or treatment.)

14.1-13 Cases which in the professional opinion of the DBP-CA attending dentist or Dental Director it is determined that a satisfactory result cannot be obtained or where the prognosis is poor or guarded (i.e. without a minimum service expectancy of 3 years).

14.1-14 Dental services received from any dental office other than a DBP-CA dental office, unless expressly authorized in writing by DBP-CA or as cited under "Out of Area Emergency Treatment."

14.1-15 Removal of asymptomatic teeth, nonpathological teeth, extractions for orthodontic purposes; surgical orthognatic procedures and crown exposure with or without ligation.

14.1-16 Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

14.1-17 Crown lengthening procedures.

14.1-18 Replacement of long-standing missing tooth/teeth in an otherwise stable dentition. (Example: teeth missing two years or longer, not currently replaced, and where adjacent and opposing teeth are in occlusion).

14.1-19 Dental services and treatments for restoring tooth structure loss from abnormal or excessive wear or attrition, abrasion, abfraction, bruxism, and/or erosion, except when due to normal masticatory function; changing or restoring vertical dimension, or occlusion, and full mouth reconstruction, diagnosis and/or treatment of the temporomandibular joint (TMJ).

14.1-20 Dental services that cannot be performed in the DBP-CA general dental office because of physical, medical or behavioral limitations of eligible enrollees over the age of seven years.

14.1-21 Pathology reports are excluded from coverage.

SECTION XV - LIMITATIONS:

15.1 Set forth below are the limitations that are applicable to this plan:

15.1-1 Prophylaxis is limited to one treatment each six-month period (including periodontal maintenance following active therapy).

15.1-2 Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a five-year period from initial placement regardless of payor. Adjustments to crowns, bridges and dentures are included in the coverage for the appliance for the first 6 months after initial placement.

15.1-3 Partial dentures (including interim partial dentures, resin-based partial dentures and metal-framework partial dentures) are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; an interim partial denture (5820 or 5821) may be replaced with a covered partial denture (5211, 5212, 5213 or 5214) no more than one time in a five year period from the placement of the interim partial denture (also known as “stayplate”).

15.1-4 Denture relines are limited to one per denture (including immediate dentures) during any 12 consecutive months.

15.1-5 Replacement will be provided for an existing denture, partial denture or bridge only if it is unsatisfactory and cannot be made satisfactory by reline or repair.

15.1-6 The plan allows up to five units of crown or bridgework per arch within a 5-year period. Upon the sixth unit, the Plan considers the treatment to be full mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit within any five-year period.

15.1-7 Non-surgical periodontal treatments (including but not limited to root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months. Surgical procedures are limited to one treatment per quadrant or area during any 36 consecutive months.

15.1-8 Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period.

15.1-9 Bitewing x-rays are limited to not more than one series in any six-month period.

15.1-10 Full mouth x-rays and panoramic type films are limited to one set every 24 consecutive months. A full mouth x-ray is defined as a minimum of 6 periapical films plus bitewing x-rays.

15.1-11 Sealant benefits include the application of sealants to permanent first and second molars and bicuspids with no decay, with no restorations and with the occlusal surface intact up to age fourteen. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

15.1-12 Single unit cast metal and/or ceramic restorations and crowns are covered only when the member is 17 years of age or older, and the tooth cannot be adequately restored with other

restorative materials. Crown build-ups including pins are only allowable as a separate procedure in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays. An allowance is made for pre-fabricated crown for children 16 and under.

15.1-13 Referral to a dental specialist (if covered) is limited to only those covered procedures that cannot be performed by a contracted general dentist, as determined by the DBP-CA Dental Director.

15.1-14 Third-molar ("wisdom teeth") extraction is limited to only those instances where the teeth cannot be treated in a more conservative manner.

15.1-15 Use of cosmetic materials is limited to anterior and posterior composite restorations (including composite restorations on the facial surfaces of premolar teeth), and porcelain-fused-to-metal cast crown restorations on posterior teeth due to decay or fracture. All other cosmetic or esthetic care is excluded from coverage.

15.1-16 The Plan benefits cast restoration using predominantly base metal. If the member requests noble or high noble metal be used (e.g., gold, semi-precious metals, etc.), the member may be charged a surcharge based on the additional laboratory charges for such metals.

15.1-17 OPTIONAL DENTAL TREATMENT: Listed copayments apply for services ONLY when prescribed by a contracted dentist as a necessary, adequate and appropriate procedure for your dental condition. In some cases there may be more than one appropriate procedure or option to address a dental condition. Optional Dental Treatment is defined as any procedure that is a dental laboratory upgrade of a standard covered service (members may be charged a surcharge based on the additional laboratory costs); OR a more extensive covered service that is an alternative to an adequate, but more conservative, covered dental service. If a member selects a more extensive form of treatment than is recommended by the contracted dentist or that is alternative to an adequate, but more conservative covered dental service, the member may be charged the <u>difference</u> between the contracted dental office's usual fee for the more extensive form of treatment, and the usual fee for the covered treatment, <u>plus</u> the copayment for the covered benefit as listed in the benefit schedule.

Imperial 1000

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Benefit Schedule

ADA	DESCRIPTION	MEMBER'S COPAYMENT
	DIAGNOSTIC SERVICES	
00120	Periodic Oral Exam - Established Patient	0
00140	Limited Oral Evaluation - Focused	0
00145	Oral Evaluation - Pt Under 3 yrs/Counseling	0
00150	Comprehensive Oral Evaluation	0
00160	Detailed & Extensive Oral Examination	0
00170	Re-evaluation - Limited	0
00180	Comprehensive Periodontal Eval	0
00210	Intraoral - Complete (Inc. Bitewings)	0
00220	Intraoral - Periapical First Film	0
00230	Intraoral - Periapical Each Additional	0
00240	Intraoral - Occlusal Film	0
00250	Extraoral - First Film	0
00260	Extraoral - Each Additional Film	0
00270	Bitewings - Single Film	0
00272	Bitewings - Two Films	0
00273	Bitewings - Three Films	0
00274	Bitewings - Four Films	0
00277	Vertical Bitewings - 7 to 8 Films	0
00330	Panorex Film	0
00460	Pulp Vitality Tests	0
00470	Diagnostic Casts	0
	PREVENTIVE SERVICES	

ADA	DESCRIPTION	MEMBER'S COPAYMENT
01110	Prophylaxis, Adult	0
01120	Prophylaxis, Child	0
01203	Topical Fluoride w/o Prophy - Child	0
01206	Topical Fluoride Varnish	0
01351	Sealant, Per Tooth	0
01510	Space Maintainer - Fixed - Unilateral	0
01515	Space Maintainer - Fixed - Bilateral	0
01520	Space Maintainer - Rem. - Unilateral	0
01525	Space Maintainer - Removable - Bilateral	0
01550	Recementation of Space Maintainer	0
01555	Removal of Fixed Space Maintainer	0
	BASIC RESTORATIVE SERVICES	
02140	Amalgam 1 Surface	0
02150	Amalgam 2 Surfaces	0
02160	Amalgam 3 Surfaces	0
02161	Amalgam 4 or More Surfaces	0
02330	Resin Composite - 1 Surface, Anterior	0
02331	Resin Composite - 2 Surfaces, Anterior	0
02332	Resin Composite - 3 Surfaces, Anterior	0
02335	Resin Comp 4+ Surf or Incisal Edge, Ant	0
02390	Composite Crown – Anterior	0
02391	Composite, 1 Surface, Post	0
02392	Composite, 2 Surfaces, Post	0
02393	Composite, 3 Surfaces, Post	0
02394	Composite - 4 or More Surface, Post	0
	ADVANCED RESTORATIVE SERVICES	
02510	Inlay - 1 Surface*	0
02520	Inlay - 2 Surface*	0
02530	Inlay - 3 Surfaces*	0
02542	Onlay - Metallic 2 Surface*	0

ADA	DESCRIPTION	MEMBER'S COPAYMENT
02543	Onlay - 3 Surfaces*	0
02544	Onlay - 4 or More Surfaces*	0
02642	Onlay - Porcelain/Ceramic - 2 Surfaces**	0
02643	Onlay - Porcelain/Ceramic - 3 Surfaces**	0
02644	Onlay - Porcelain/Ceramic - 4+ Surfaces**	0
02710	Crown - Resin Based Composite Indirect**	0
02712	Crown 3/4 Resin Based Composite Indirect**	0
02720	Crown Resin with High Noble*, **	0
02721	Crown Resin w/Predom. Base Metal**	0
02722	Crown Resin Noble*, **	0
02740	Crown - Porcelain/Ceramic Substrate**	0
02750	Crown - Porc Fused/High Noble Metal*, **	0
02751	Crown - Porc Fused/Pred Base Metal**	0
02752	Crown - Porc Fused To Noble Metal*, **	0
02780	Crown - 3/4 Cast High Noble Metal*	0
02781	Crown - 3/4 Cast/Predom Base Metal	0
02782	Crown - 3/4 Cast Noble Metal*	0
02783	Crown - 3/4 Porcelain/Ceramic**	0
02790	Crown - Full Cast High Noble Metal*	0
02791	Crown - Full Cast/Predom Base Metal	0
02792	Crown - Full Cast Noble Metal*	0
02794	Crown - Titanium*	0
02910	Recement Inlay/Onlay/Partial Coverage Rest	0
02915	Recement Cast/Prefab Post & Core	0
02920	Recement Crown	0
02930	Prefab Stain. St. Crown Prim	0
02931	Prefab Stain. St. Crown Perm	0
02932	Prefab Resin Crown**	0
02934	Prefab Esthetic Coated Stain St Crn Prim*, **	0
02940	Sedative Fillings	0

ADA	DESCRIPTION	MEMBER'S COPAYMENT
02950	Core Build-up, Including Pins	0
02951	Pin Retention - Per Tooth, w/Restoration	0
02952	Cast Post/Core In Add. To Crown*, Indirect Fab	0
02953	Ea Add Ind Fab Post - Same Tooth (Inc Canal Prep)*	0
02954	Prefab/Post & Core In Add. To Crown	0
02957	Ea Add Prefab Post - Same Tooth	0
02970	Temporary Crown (Fractured Tooth)	0
	ENDODONTIC SERVICES	
03110	Pulp Cap - Direct (w/o Final Restoration)	0
03120	Pulp Cap - Indirect (w/o Final Restoration)	0
03220	Therapeutic Pulpotomy (w/o Final Rest)	0
03221	Gross Pulpal Debridement	0
03230	Pulpal Therapy Anterior Primary	0
03240	Pulpal Therapy Post Primary	0
03310	Root Canal, Anterior (w/o Final Rest)	0
03320	Root Canal, Bicuspid (w/o Final Rest)	0
03330	Root Canal, Molar (w/o Final Rest)	0
03332	Inc Endo Ther., Inoper/Unrest/Fx Tooth	0
03346	Retreatment Previous RCT - Anterior	0
03347	Retreatment Previous RCT - Bicuspid	0
03348	Retreatment Previous RCT - Molar	0
03351	Apexification, Initial visit	0
03352	Apexification, Interim visit	0
03353	Apexification, Final visit	0
03410	Apicoectomy, Anterior	0
03421	Apicoectomy, Bicuspid (First Root)	0
03425	Apicoectomy, Molar (First Root)	0
03426	Apicoectomy, Each Additional Root	0
03430	Retrograde Filling (Per Root)	0
03450	Root Amputation (Per Root)	0

ADA	DESCRIPTION	MEMBER'S COPAYMENT
03920	Hemisection (Inc Root Rem) w/o RCT	0
	PERIODONTAL SERVICES	
04210	Gingivectomy/Gingivoplasty (4+ Teeth)	0
04211	Gingivectomy/Gingivoplasty (1-3 Teeth)	0
04240	Gingival Flap w/Root Planing (4+ Teeth)	0
04241	Gingival Flap With Rp (1 to 3 Teeth)	0
04260	Osseous Surgery (4+ Teeth)	0
04261	Osseous Surgery (1 to 3 Teeth)	0
04270	Pedicle Soft Tissue Graft Procedure	0
04271	Free Soft Tissue Gr w/Donor Site Surg	0
04274	Distal/Proximal Wedge Procedure	0
04341	Perio Scaling & RP (4+ Teeth)	0
04342	Perio Scale & RP (1 to 3 Teeth)	0
04910	Perio. Maint. Procedure	0
	REMOVABLE PROSTHODONTICS	
05110	Complete Denture - Maxillary	0
05120	Complete Denture - Mandibular	0
05130	Immediate Denture - Maxillary	0
05140	Immediate Denture - Mandibular	0
05211	Maxillary Partial Denture - Resin Base	0
05212	Mandibular Partial Denture - Resin Base	0
05213	Max Partial Denture - Cast Metal Frame*	0
05214	Mand Partial Denture - Cast Metal Frame*	0
05225	Max Partial Denture - Flexible Base***	0
05226	Mand Partial Denture - Flexible Base***	0
05410	Adjust Complete Denture - Maxillary	0
05411	Adjust Complete Denture - Mandibular	0
05421	Adjust Partial Denture - Maxillary	0
05422	Adjust Partial Denture - Mandibular	0
05510	Repair Broken Complete Denture Base	0

ADA	DESCRIPTION	MEMBER'S COPAYMENT
05520	Replace Missing/Broken Teeth - Per Tooth	0
05610	Repair Resin Denture Base	0
05620	Repair Cast Framework	0
05630	Repair or Replace Broken Clasp	0
05640	Replace Broken Teeth - Per Tooth	0
05650	Add Tooth to Existing Partial Denture	0
05660	Add Clasp to Existing Partial Denture	0
05670	Replace All Teeth - Maxillary	0
05671	Replace All Teeth - Mandibular	0
05710	Rebase Complete Maxillary Denture	0
05711	Rebase Complete Mandibular Denture	0
05720	Rebase Maxillary Partial Denture	0
05721	Rebase Mandibular Partial Denture	0
05730	Reline Comp Maxillary Denture - Chair	0
05731	Reline Comp Mandibular Denture - Chair	0
05740	Reline Maxillary Partial Denture - Chair	0
05741	Reline Mandibular Partial Denture - Chair	0
05750	Reline Complete Maxillary Denture - Lab	0
05751	Reline Complete Mandibular Denture - Lab	0
05760	Reline Maxillary Partial Denture - Lab	0
05761	Reline Mandibular Partial Denture - Lab	0
05820	Interim Partial Denture, Maxillary	0
05821	Interim Partial Denture, Mandibular	0
05850	Tissue Conditioning, Maxillary	0
05851	Tissue Conditioning, Mandibular	0
	FIXED PROSTHODONTICS	
06205	Pontic - Indirect Resin Based Composite**	0
06210	Pontic - Cast High Noble Metal*	0
06211	Pontic - Cast Predom Base Metal	0
06212	Pontic - Cast Noble Metal*	0

ADA	DESCRIPTION	MEMBER'S COPAYMENT
06214	Pontic - Titanium*	0
06240	Pontic - Porcelain/High Noble Metal*, **	0
06241	Pontic - Porcelain/Predom Base Metal**	0
06242	Pontic - Porcelain/Noble Metal*, **	0
06245	Pontic - Porcelain/Ceramic**	0
06250	Pontic Resin High Noble Metal*, **	0
06251	Pontic Resin w/Predom. Base Metal**	0
06252	Pontic Resin w/Noble Metal*, **	0
06545	Retainer - Cast Mtl For Resin Fxd Pros	0
06548	Ret - Porc/Cer for Resin Bonded Fixed Pros**	0
06710	Crown - Indirect Resin Based Composite**	0
06720	Crown - Resin High Noble Metal*, **	0
06721	Crown - Resin w/Predom Base Metal**	0
06722	Crown - Resin w/Noble Metal*, **	0
06740	Crown - Porcelain/Ceramic**	0
06750	Crown - Porc/High Noble Metal*, **	0
06751	Crown - Porc/Predom Base Metal**	0
06752	Crown - Porc/Noble Metal*, **	0
06780	Crown - 3/4 Cast High Noble Metal*	0
06781	Crown - 3/4 Cast Predom Based Metal	0
06782	Crown - 3/4 Cast Noble Metal*	0
06783	Crown - 3/4 Porcelain/Ceramic**	0
06790	Crown - Full Cast High Noble Metal*	0
06791	Crown - Full Cast Predom Base Metal	0
06792	Crown - Full Cast Noble Metal*	0
06794	Crown - Titanium*	0
06930	Recement Fixed Partial Denture	0
06970	Post/Core - Add to Bridge Retainer* - Indirect Fab	0
06972	Prefab. Post/Core - Add to Fixed Part Ret	0
06973	Core Buildup For Retainer Inc Pins	0

ADA	DESCRIPTION	MEMBER'S COPAYMENT
06976	Each Add'l Indirectly Fab Post - Same Tooth*	0
06977	Each Add Prefab Post - Same Tooth*	0
	ORAL SURGERY	
07111	Extraction Coronal Remnants - Prim Tooth	0
07140	Extraction - Erupted Tooth/Exposed Root	0
07210	Surg Rem/Erupted Tooth - Req Elevation	0
07220	Removal Impacted Tooth - Soft Tissue	0
07230	Removal Impacted Tooth - Part Bony	0
07240	Rem. Impacted Tooth - Comp Bony	0
07241	Rem. Impacted Tooth - Comp Bony w/Comp	0
07250	Surgical Removal Residual Tooth Roots	0
07285	Biopsy of Oral Tissue - Hard	0
07286	Biopsy of Oral Tissue - Soft	0
07287	Exfoliative Cytological Sample Collection	0
07288	Brush Biopsy - Trans Sample Collection	0
07310	Alveoloplasty w/Ext - 4+ Teeth/Spaces, per quad	0
07311	Alveoloplasty w/Ext (1 to 3 Teeth/Sp)	0
07320	Alveoloplasty w/o Ext - 4+ Teeth/Spaces, per quad	0
07321	Alveoloplasty w/o Ext (1 to 3 Teeth/Sp)	0
07510	I & D of Abscess, Intraoral Soft Tissue	0
07511	I & D of Abscess, Intraoral Complicated	0
07520	I & D of Abscess, Extraoral Soft Tissue	0
07521	I & D of Abscess, Extraoral Complicated	0
07530	Rem of Forgn Body - Skin/Subcutaneous	0
07960	Frenulectomy - Separate Procedure	0
07963	Frenuloplasty	0
	ADJUNCTIVE SERVICES	
09110	Palliative (Emergency) Treatment	0
09120	Fixed Partial Denture Sectioning	0
09310	Consult - Diag Srv Provided by another DDS	0

ADA	DESCRIPTION	MEMBER'S COPAYMENT
09430	Office Visit for Observation	0
09440	Office Visit After Regular Sched Hours	25
09450	Case Presentation	0
09930	Treatment of Complications, By Report	0
09951	Occlusal Adjustment Limited	0
09971	Odontoplasty	0

*If titanium, noble or high noble metals are requested for fillings, crowns, inlays, onlays, pontics, bridges, or prosthetic devices, there will be an additional charge, based on the amount of metal used.

**Member pays an additional $100 fee for resin or porcelain on molars.

***Flexible base partial dentures are subject to an additional charge based on additional laboratory.

ALPINE V

ORTHODONTIC BENEFITS

I. ORTHODONTIC BENEFITS

Orthodontic services are provided as part of dental benefits provided by Dental Benefit Providers of California,Inc. ("DBP-CA"), subject to the following provisions::

a) There shall be a one-time surcharge of **$2250.00** for a full-banded/2 year case, (Phase II treatment only), plus an additional charge of no more than:

$350.00 for start-up fees

$150.00 for one set of retainers (with retention limited to 12 consecutive months, if necessary)

Member's payment schedule shall be as follows unless otherwise agreed upon between the member and the orthodontist:

$750.00 at the inception of care (the placement of bands).

$150.00 per month for 10 months.

b) Orthodontic treatment is available for each eligible member, spouse and dependents starting at age 10. Eligible dependents with qualified student status are covered based on general dental plan coverage. Please consult with your plan administrator.

c) Orthodontic treatment must be provided by a member of the orthodontic panel who is providing said treatment under a contract with DBP-CA.

d) Plan benefits cover 24 months of usual and customary Phase II orthodontic treatment

II. LOSS OF BENEFIT/RESIDUAL OBLIGATIONS

Should a member be terminated or become ineligible for benefits, the member is subject to the following provisions:

a) Availability of the orthodontic benefits described herein will cease upon loss of members eligibility and/or termination of the Group Subscriber Agreement for any reason. In the event benefits terminated while members and/or dependents have treatment in progress, the member may complete treatment by payment of the lesser of the following:

1) The number of months remaining in treatment times $125 per month

2) $3000 less any copayments (including start-up fees) paid prior to termination of this benefit.

b) If a termination of benefits occurs due to a termination of the Group Subscriber Agreement, the group shall reserve the right to assign members residual obligation as described in (a) above to a successor organization.

c) If member loses eligibility for 3 or more consecutive months they will be considered no longer eligible for orthodontic benefits, and (1) above would apply.

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d) Subject to 1b above, dependents other than spouse will lose benefits.

III. ADDITIONAL CHARGES

a) Treatment that extends beyond 24 months will be subject to an office visit charge, which will be the members responsibility.

b) The charge for each additional month will not exceed $125.00 per month.

IV. SERVICES NOT PROVIDED

The following are <u>not</u> benefits included as part of orthodontic services provided by DBP-CA.

a) Start-up including:

1. Cephalometric X-rays*
2. Tracings*
3. Study models*
4. Photos*

b) Lost or broken appliances.

c) Retreatment of orthodontic cases.

d) Treatment in progress at inception of eligibility.

e) Changes in treatment necessitated by accident of any kind.

f) Extraction of teeth or surgical procedures performed for orthodontic purposes.

g) Replacement (including bridgework) or restoration (including crowns) of teeth caused solely by the orthodontic treatment.

h) Orthodontics for TMJ problems including assessment beyond that customarily provided in general practice.

i) Cases involving:

1. Surgical orthodontics.
2. Myofunctional therapy.
3. Cleft palate.
4. Micrognathia.
5. Macroglossia.
6. Hormonal imbalances.
7. Phase I orthodontic care.
8. Orthodontic care prior to age ten or for adult dependents who no longer qualify for student status.

j) Transfer of Orthodontic provider for any reason in the middle of treatment.

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k) Orthodontic cases extending beyond the allowed age of coverage are subject to loss of benefit/residual obligation provision (refer to SECTION II LOSS OF BENEFIT/RESIDUAL OBLIGATIONS).

l) Any treatment rendered by any noncontracted Orthodontic provider.

* Start-up fees subject to additional combined charge not to exceed $350.00.

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