



CALIFORNIA

Combined Evidence of Coverage and Disclosure Form (HMO)
Dental, Group

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Welcome to PacifiCare Dental

WHAT IS THIS PUBLICATION?

This publication is called a *Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your dental care plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section 10. Definitions**.

Whether you are the Subscriber of this coverage or enrolled as a Dependent, your *Combined Evidence of Coverage and Disclosure Form* is a key to making the most of your membership. You'll learn about important topics like how to select an Assigned Dental Provider Group and what to do if you need Emergency Dental Services.

WHAT ELSE SHOULD I READ TO UNDERSTAND MY BENEFITS?

Along with reading this publication, be sure to review your *Schedule of Benefits* and any supplemental benefit materials. Your *Schedule of Benefits* provides the details of your particular Dental Plan, including any Copayments that you may have to pay when obtaining a dental service. Together, these documents explain your coverage.

Your *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* provide the terms and conditions of your coverage with PacifiCare Dental, and all applicants have a right to view these documents prior to enrollment. The *Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

WHAT IF I STILL NEED HELP?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service Department at 1-800-228-3384 (TTY/TDD 1-877-735-2929).

THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM IS ONLY A SUMMARY OF THE BENEFIT PLAN. MEMBERS MUST CONSULT THE GROUP AGREEMENT TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A SPECIMEN COPY OF THE GROUP AGREEMENT WILL BE FURNISHED TO MEMBERS UPON REQUEST.

A STATEMENT DESCRIBING PACIFICARE DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO MEMBERS UPON REQUEST.

You may correspond with PacifiCare Dental at the following address:

PacifiCare Dental
P.O. Box 25187
Santa Ana, CA 92799-5187
1-800-228-3384

PacifiCare Dental Web site:
www.pacificare-dental.com

1. Getting Started

CHOOSING A DENTAL PROVIDER GROUP (CHOICE OF PROVIDERS)

One of the first things you do when joining PacifiCare Dental is to select a Dental Provider Group from the Provider Directory, which lists dental offices covered under your Dental Plan. You must write your office selection on your Enrollment Application when you enroll in the Dental Plan. If the office you selected is not available, or you fail to select an office, we will assign a dental office to you. If you wish to select another dental office, you may contact Customer Service at the number listed below.

Once you select an Assigned Dental Provider Group or we assign a dental office to you, you can make an appointment by simply calling that office. The name, address, and phone number of your Assigned Dental Provider Group appears on your PacifiCare Dental ID Card. If you have any further questions regarding location, office hours or emergency hours or other providers in your area, or to request a copy of the Provider Directory, you may contact Customer Service at 1-800-228-3384 to receive that information. You can also find an online version of the Directory at www.pacificare-dental.com.

If you have questions about the days and hours your Assigned Dental Provider Group is open, please feel free to call them and ask.

LIABILITY OF MEMBERS FOR PAYMENT

Dental benefits are covered only if dental services are obtained from your Assigned Dental Provider Group, or are provided as Emergency Dental Services as described in **Section 3. Emergency Dental Services**. The fees for any dental procedures not provided by your Assigned Dental Provider Group or not provided as Emergency Dental Services may be the responsibility of the Member at the Provider's billed charges.

WHEN YOUR COVERAGE BEGINS

Your Dental Plan coverage will begin on the 1st of the month, at your Assigned Dental Provider Group, IF:

- You were enrolled before the 1st of the month, AND
- We have received your group or employer's payment for your first month's benefits.

CONTINUITY OF CARE:

CONTINUITY OF CARE FOR NEW MEMBERS

Under certain circumstances, new Members of PacifiCare Dental may be able to temporarily continue receiving services from a Non-Participating Provider. This transition assistance is intended for new Members who, upon their effective date of coverage, are undergoing treatment for an Acute Condition or Serious Chronic Condition with a Non-Participating Provider, or are scheduled for a surgery or other procedure that is authorized by PacifiCare Dental as part of a documented course of treatment and has been recommended and documented by a Non-Participating Provider to occur within 180 days of the Member's effective date of coverage.

If you're a new Member and believe you qualify for continuity of care, please call the Customer Service Department at 1-800-228-3384 and request the form "Continuity of Care for New Enrollees Request." Complete and return this form to PacifiCare Dental as soon as possible. Upon receiving the completed form, a review will be completed in 3 business days. If you qualify, you will be notified by telephone of the decision and provided with the plan of your care. If you don't qualify, attempts will be made to notify you by telephone of the decision. You will be notified in writing within 3 business days of the completed review, and alternatives will be offered.

CONTINUITY OF CARE WITH A TERMINATED PROVIDER

You may be eligible to continue receiving care from a terminated dental Provider if the Provider didn't voluntarily end its contract with PacifiCare Dental. Continuity of Care shall be provided for those Members who are undergoing treatment for an Acute Condition or a Serious Chronic Condition by a Provider whose contract with the Plan has been terminated, or are scheduled for a surgery or other procedure that is authorized by PacifiCare Dental as part of a documented course of treatment and has been recommended and documented by a terminated Provider to occur within 180 days of the contract's termination date. If you are receiving treatment for any of these conditions, you may contact our Customer Service Department to request continuing treatment by the terminated dental Provider.

Unless the Plan's termination of the Provider's contract is for professional disciplinary reasons as described in California Business and Professions Code §805 (a)(6), or for fraud or other criminal activity, the Plan will allow the Member to continue treatment with the terminated Provider. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were in the Provider's contract prior to termination by PacifiCare Dental. Rates for the dentist's services must be similar to rates and methods of payment used by the Plan or group for currently contracting Providers providing similar services who are not capitated. If these various conditions are not met, you will not be eligible to continue the services of the terminated Provider.

PacifiCare Dental must pre-authorize or coordinate services for continued care. If you have any questions, want to appeal a denial, or would like a copy of PacifiCare's Continuity of Care Policy, call our Customer Service Department.

2. Seeing the Dentist

SCHEDULING APPOINTMENTS

To visit your dentist, simply make an appointment by calling your Assigned Dental Provider Group. When you see your dentist you may be required to pay a charge for the visit. This charge is called a Copayment. The amount of a Copayment depends upon the dental service. Your Copayments are outlined in your *Schedule of Benefits*. More detailed information can also be found in **Section 6. Payment Responsibility**.

SECOND OPINIONS

A Member, or his or her treating Participating Provider, may submit a request for a second dental opinion to PacifiCare Dental by writing or calling our Customer Service Department at 1-800-228-3384. Referrals to a Provider for second dental opinions will be provided when requested. When the Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function; or the normal time frame for the decision-making process, as described below, would be detrimental to the Member's life or health or could jeopardize the Member's ability to regain maximum function; a request for a second opinion shall be processed in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after PacifiCare Dental's receipt of the information reasonably necessary and requested by PacifiCare Dental to make the determination. When the Member's condition does not create an imminent and serious threat to his or her health, a request for a second opinion shall be processed in a timely fashion appropriate for the nature of the Member's condition, not to exceed 5 business days after receipt of the information reasonably necessary and requested by PacifiCare Dental to make the determination. The requesting Participating Provider will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to a requesting Member verbally (when possible) and in writing within 2 business days.

Second dental opinions will be rendered by an appropriately qualified dental professional. An appropriately qualified dental professional is a licensed health care dental Provider who is acting within his or her scope of practice and who possesses the clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second dental opinion.

If the Member is requesting a second dental opinion about care received from his or her Assigned Dental Provider Group, the second dental opinion will be provided by an appropriately qualified health care professional within the PacifiCare Dental Participating Provider network. If the Member is requesting a second dental opinion about care received from a Specialist, the second dental opinion will be provided by a Specialist within the PacifiCare Dental Participating Provider network of the same or equivalent specialty.

A second dental opinion is an examination by an appropriately qualified dental professional documented by a consultation report. The consultation report will be made available to the Member and PacifiCare Dental, and may include an evaluation of previously performed procedures, as well as any recommended procedures or tests that the dental professional providing the second opinion believes are appropriate. If the Provider giving the second dental opinion recommends a particular treatment, diagnostic test or service covered by PacifiCare Dental, the treatment, diagnostic test or service will be provided or arranged by the Member's Assigned Dental Provider Group or by an appropriately qualified dental professional within the PacifiCare Dental Participating Provider network. However, the fact that an appropriately qualified dental professional furnishing a second dental opinion recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is a Covered Service under the Member's PacifiCare Dental Plan. All care is subject to the limitations and exclusions listed in this *Combined Evidence of Coverage and Disclosure Form*. The Member shall be responsible for paying any dental Copayments, as set forth in the Member's *Schedule of Benefits*, to the PacifiCare Participating Provider who renders the second dental opinion to the Member.

REFERRAL TO A SPECIALIST

Specialty referral benefits include the provision of Covered Services by endodontists, periodontists, pedodontists, orthodontists and oral surgeons. PacifiCare Dental's *Schedule of Benefits* includes more detailed information concerning a Member's benefit package. If your Dental Plan has a specialty referral benefit and/or orthodontic referral benefit, your Assigned Dental Provider Group will assess your need for a referral to a dental Specialist and will initiate a referral to a Specialist on behalf of the Member if appropriate.

- PacifiCare Dental will not pay more than the specialty family calendar year maximum listed in your *Schedule of Benefits*, if any. Any specialty fees for a family over and above the maximum during a calendar year are not covered by PacifiCare Dental, and are the responsibility of the Member.
- Listed Copayments do not apply to Covered Services provided by a pedodontist. Instead, the parent or guardian is responsible for 49% of the pedodontist's contracted rate, subject to the specialty family calendar year maximum, if any. PacifiCare Dental will not pay more than the specialty family calendar year maximum listed in your *Schedule of Benefits*, if any. Sample out-of-pocket expenses are shown in your *Schedule of Benefits*.

Except for pedodontic services, when specialty services are provided, the Member's financial responsibility is limited to applicable Copayments and any fees in excess of the specialty family calendar year maximum. Copayments are listed in the Member's *Schedule of Benefits*.

3. Emergency Dental Services

What to Do When You Require Emergency Dental Services

EMERGENCIES

Your Assigned Dental Provider Group will be available for Emergency Dental Care 24 hours a day, 7 days a week.

If you need Emergency Dental Care (for example, due to pain, bleeding or swelling, infection or drainage) you must contact your Assigned Dental Provider Group. If you are outside PacifiCare Dental's Service Area and in need of Urgent Dental Services or if your acute emergent dental condition prevents you from contacting your Assigned Dental Provider Group, you may receive care by any licensed dentist. However, you must use the emergency dentist ONLY for relief of pain, or to immediately diagnose and treat a condition that a reasonable person with no special knowledge of dentistry under the circumstance would believe that, if not given immediate attention, may seriously jeopardize the health of the member, seriously impair bodily functions, or result in serious dysfunction of a bodily organ or part. PacifiCare Dental will cover out-of-area follow-up care by a Non-Participating Provider as long as the care continues to meet the definition of Emergency Dental Care.

We will reimburse you for these covered Emergency Dental Services only, subject to applicable Copayments. To receive reimbursement, you do not have to submit a claim form. All you have to do is send us, within 90 days, the itemized bill, marked "PAID," along with a brief explanation of why the Emergency Dental Services were necessary. We will provide reimbursement within 30 days of receipt.

All reimbursement requests should be mailed to:

PacifiCare Dental, M/S LC05-293
P.O. Box 25187
Santa Ana, CA 92799-5187

4. Changing Your Assigned Dental Provider Group

There may come a time when you want or need to change your Assigned Dental Provider Group. This section explains how to make this change, as well as how we continue your care.

CHANGING YOUR ASSIGNED DENTAL PROVIDER GROUP

You may transfer to another Assigned Dental Provider Group if you have no Treatment In Progress. All Treatment In Progress started at your current Assigned Dental Provider Group should be completed before a change, unless a quality-of-care issue is identified. If you wish to select another dental office, you may contact Customer Service at 1-800-228-3384. If you elect to change offices without completing Treatment In Progress, you may be responsible for all billed charges by your new Assigned Dental Provider Group. If you owe your Assigned Dental Provider Group any money, you will be asked to settle your account at the time you transfer.

PacifiCare Dental reviews transfer requests on a case-by-case basis. If you meet the above requirements and call us by the 20th of the current month, your transfer will be effective on the first day of the following month. If you meet the criteria but your request is received after the 20th of the current month, your transfer will be effective the first day of the second succeeding month. For example, if you meet the above requirements and you call PacifiCare Dental on June 17th to request a new Assigned Dental Provider Group, the transfer will be effective on July 1st. If you meet the above requirements and you call PacifiCare Dental on June 21st, the transfer will be effective August 1st.

Transfer of records at the Member's initiation will be subject to a duplication fee of \$.25 per page or \$.50 per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. Duplication of X-rays will be subject to a fee of \$10.00 per sheet.

Should a Participating Provider not be available within a reasonable distance from your Primary Residence or Primary Workplace, you will be referred by PacifiCare Dental to a Non-Participating Provider and instructed on reimbursement procedures for service costs in excess of Plan Copayments. For reimbursement procedure information, please contact Customer Service at 1-800-228-3384.

WHEN WE CHANGE YOUR ASSIGNED DENTAL PROVIDER GROUP

Under special circumstances, PacifiCare Dental may require that a Member change his or her Assigned Dental Provider Group. Generally, this happens at the request of the Assigned Dental Provider Group after a material detrimental change in its relationship with a Member. If this occurs, we will notify the Member of the effective date of the change, and we will transfer the Member to another Assigned Dental Provider Group, provided he or she is medically able and there is an alternative Assigned Dental Provider Group within 30 miles of the Member's Primary Residence or Primary Workplace.

PacifiCare will also notify the Member in the event that the agreement terminates between PacifiCare and the Member's Assigned Dental Provider Group. If this occurs, PacifiCare will provide 30 days' notice of the termination. PacifiCare will also assign the Member a new Assigned Dental Provider Group. If the Member would like to select a different Assigned Dental Provider Group, he or she may do so by contacting Customer Service. Upon the effective date of transfer, the Member can begin receiving services from his or her new Assigned Dental Provider Group.

5. Your Dental Benefits

DENTAL BENEFITS

Your dental benefits include *specific* diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral surgery, adjunctive dental services, and other services, as applicable to your specific PacifiCare Dental plan. You should refer to your *Schedule of Benefits* for a complete list of the Dental Plan's benefits. Listed procedures in the *Schedule of Benefits* are Covered Services only when diagnosed as appropriate treatment by your Assigned Dental Provider Group. For any Copayments that may be associated with a benefit, you should also refer to your *Schedule of Benefits*.

PacifiCare Participating Providers and contracted Specialists may offer Members dental services that are not included on the *Schedule of Benefits*, and for which there are no alternative listed Covered Services. In such cases, the PacifiCare Participating Provider and contracted Specialist may offer the service at the Provider's Billed Charges. For example, if a Provider offers, and the Member consents to, cosmetic tooth bleaching, there is no alternative Covered Service and the Provider may charge the Provider's Billed Charges.

PacifiCare Participating Providers will ask all Members to sign an informed consent document detailing the risks, benefits and alternatives to all recommended treatments. The Member may choose the least expensive clinically acceptable procedure (such as extraction and not a crown and root canal therapy). In the performance of recommended dental treatments, outcomes cannot always be accurately predicted. Sometimes, during a specific procedure, an immediate change in treatment may be required. In these instances, the Participating Provider must stop the procedure and fully inform the Member of the change in treatment, risks, and financial impact.

TREATMENT PLAN DECISION-MAKING WHEN TWO OR MORE TREATMENT ALTERNATIVES ARE COVERED SERVICES

When several Covered Services are treatment alternatives for diagnosed care, each alternative is considered a Covered Service. The determination of which Covered Service best meets the Member's needs is the decision of the Assigned Dental Provider Group in concert with the Member. In such cases, either Covered Service would be available to the Member at the listed Copayment. An example of this situation is the decision with regard to the replacement of bilateral missing teeth. In this scenario, either the removable partial denture or the fixed bridges would be considered Covered Services. The choice would be made by the Assigned Dental Provider Group and Member considering professionally recognized standards of care, clinical condition of each restoration, technical difficulty of both restorative alternatives, and any other factors that may be present with regard to the Member's specific dental condition.

LIMITATION OF BENEFITS

1. PROPHYLAXIS - Routine cleaning of teeth, including scaling and polishing procedures to remove coronal plaque, calculus and stains, is an allowable preventive benefit once every 6 months.
2. FULL MOUTH RADIOGRAPHS (X-rays) are limited to once in any 2-year period. Bitewing X-rays are limited to no more than 1 series of 4 films in any 6-month period.
3. FLUORIDE TREATMENTS are limited to only once per calendar year.
4. PERIODONTAL SCALING AND ROOT PLANING - Both procedures are allowable only when the need can be demonstrated radiographically and/or by pocket charting. There is a maximum of 4 quadrants per calendar year.
5. PERIODONTAL MAINTENANCE PROCEDURES are a benefit following active therapy (previous to periodontal treatment) once every 6 months at the Specialist's office when referred by your Assigned Dental Provider Group, or provided at your Assigned Dental Provider Group
6. PROSTHETICS
 - A. REMOVABLE PROSTHETICS
 - 1) Temporary or Transitional Dentures - Temporary or transitional full dentures are not a covered benefit. However, with some benefit packages, an exception is made for an anterior stayplate when this interim appliance either:
 - a) Replaces natural, permanent, anterior teeth, during the healing period immediately after extraction or traumatic tooth loss; or
 - b) Replaces extracted or lost natural, permanent, anterior teeth for Members under 16 years of age.
 - 2) Laboratory Upgrades including specialized services for Dentures are not covered. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the dentist by the dental laboratory for the upgrade. Upgrades include, but are not limited to:
 - a) Precious metal for removable appliance framework or a metal base for a full denture;
 - b) Personalization and characterization;
 - c) Specialized materials;
 - d) Specialized services or techniques involving precision attachments or stress breakers.

Your Dental Benefits

3) Dentures, Replacement, Repairs and Relines

- a) For existing full or partial dentures, the addition of new denture teeth is covered if a natural tooth or a denture tooth is lost. Replacement of an existing full or partial denture is covered.
- b) If an existing permanent denture needs to be repaired and/or relined to be made serviceable, then repairs and/or relines are also a benefit. The addition of denture teeth, repairs and relines of secondary ("back-up," "spare" or "temporary") dentures are not covered benefits.
- c) Denture adjustments - Adjustments for new dentures are included in the Copayment for the denture for 6 months following delivery. For existing dentures, or new dentures after the initial 6 months, the Member is responsible for the listed Copayment for a denture adjustment. Adjustments of secondary ("back-up" or "spare") dentures are not a covered benefit.

B. FIXED PROSTHETICS:

1) A fixed bridge is a benefit to replace missing natural teeth, unless based on professionally recognized standards:

- a) The clinical condition of the teeth that would support the bridge is unfavorable.
- b) There are inadequate teeth available to support the bridge.
- c) The same dental arch has a serviceable existing partial denture to which additional denture teeth may be added to replace the missing natural teeth.
- d) The new bridge would replace an existing bridge that is still serviceable.
- e) A bridge would be used only to realign malaligned teeth.

2) A fixed bridge is a benefit to replace missing natural teeth, unless:

- a) The requested service is for a new bridge and a new partial denture in the same arch. In such cases the Covered Service is for a partial denture that would replace all missing teeth in the arch or multiple bridges.
- b) A Member under 16 years of age loses a permanent tooth; in which case an anterior stayplate or space maintainer would be the covered benefit to replace the missing tooth. If the bridge is placed, patient or guardian must pay the dentist's billed charges.
- c) The bridge would be supported in whole or in part by dental implants, or acid-etched resin bridge retainers (a "Maryland" bridge). A bridge would be used only to realign malaligned teeth.
- d) It is a long spanning bridge (anything beyond 4 abutments and/or pontics).
- e) The bridge would have an abutment (support) only on 1 side (cantilever bridge).

C. SINGLE CROWNS, INLAYS AND ONLAYS

Single crowns, inlays and onlays will be covered when there is not enough retentive quality left in a tooth to hold a filling, or if the tooth requires cuspal protection to avoid an unacceptable risk of tooth fracture. The use of specialized materials, i.e., precious or semi-precious metals in crowns, is considered a laboratory upgrade, which the dentist may offer the Member for a fee not to exceed the amount charged to the dentist by the dental laboratory for the upgraded materials. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the dentist by the dental laboratory for the upgrade. For example, the Provider offers, and the Member accepts, the alternative of a precious (gold) crown instead of a base metal crown. The Provider may charge no more than the listed Copayment for the base metal crown, plus the actual fee charged by the dental laboratory for the use of the precious metal and/or any other specialized material.

- 1) Porcelain, porcelain-fused-to-metal (PFM), and cast metal crowns are not a benefit for children under 16 years of age. The benefit in such cases is a prefabricated stainless steel or resin crown. If a porcelain, PFM, or cast metal crown is performed, the parent or guardian must pay the Provider's Billed Charges.
- 2) Replacement of an inlay, onlay, porcelain or PFM crown is a covered benefit as long as the existing restoration is unserviceable, and can not be made serviceable, as determined by your assigned dentist.
- 3) For crowns and fixed bridges, the maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges.

7. **OCCLUSAL EQUILIBRATION** – This means the reshaping of the biting surfaces of the teeth to create harmonious contact and relationships between teeth in the upper and lower jaw. Adjustment of the bite on a new restoration, crown, bridge, and denture will be provided at no additional charge if performed by the PacifiCare Participating Provider who provided the restoration service. However, the correction of occlusion on natural teeth or existing restorations is not a Covered Service.

8. DOWEL POSTS AND PINS - Dowel posts are a benefit for teeth that have had root canal therapy and lack sufficient structure to otherwise support and retain a crown. Pins are a separate Covered Service if deemed necessary by a PacifiCare Participating Provider to provide adequate retention of a restoration.
9. SPECIALTY REFERRAL - The BENEFIT of dental treatment by a Specialist is limited to:
 - Dental plans which include specialty referral benefits
 - Covered dental services performed by an oral surgeon, endodontist and periodontist that are beyond the scope of practice of a general dentist
 - Pedodontic referrals apply to all children through age 18 as necessary
 - Services by an orthodontist, if the Member's Dental Plan specifically includes PacifiCare Dental's orthodontic benefit.

Specialty Referral Maximum - PacifiCare Dental will not pay more than the specialty family calendar year maximum listed in the *Schedule of Benefits*, if applicable. Any specialty fees for a family over and above the maximum during a calendar year are not covered by PacifiCare Dental, and are the responsibility of the Member.

10. RESTORATIONS AND DENTAL PROSTHETICS
 - A. Restorations and/or fixed or removable prosthetics needed solely to increase vertical dimension or restore the occlusal plane are not Covered Services. To restore the occlusal plane means oral rehabilitation using crown(s), bridge(s), filling(s), and/or denture(s) to establish an altered bite or relationship between the jaws.
 - B. Composite restorations on posterior teeth may not be a benefit for all plans. Please refer to your *Schedule of Benefits*.
11. I.V. SEDATION OR GENERAL ANESTHESIA - Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).

EXCLUSION OF BENEFITS

The following procedures and services are excluded and not Covered Services:

1. Specialty referral benefits, unless otherwise indicated in the *Schedule of Benefits*, are not covered.
2. Services provided by a prosthodontist are not covered.
3. Cosmetic dental care is not covered.
4. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Member's Assigned Dental Provider Group, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the *Schedule of Benefits*.
5. Treatment of fractured bones and dislocated joints is not covered.
6. Lost or stolen dentures are not covered.
7. Crowns or bridgework that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation, or poor margins (as previously determined in an examination by the Assigned Dental Provider Group or based upon a review of a pre-existing radiograph).
8. Lost, stolen or broken orthodontic appliances are not covered.
9. Services that are provided to the Member by a state government or agency thereof, or are provided without cost to the Member by a municipality, county or other subdivision are not covered.
10. Charges for services rendered after termination of the Member's eligibility under the Dental Plan are not covered.
11. Work-in-progress: Dental expenses incurred in connection with any portion of the dental services started prior to the effective date of coverage are excluded. The completion of dental or orthodontia services started before the Member's application date or effective date of coverage with PacifiCare Dental, whichever is earlier, or started by a Non-Participating Provider without the prior approval of PacifiCare Dental is not covered. This exclusion does not apply to a current Member:
 - who has temporary restorative services
 - whose tooth was opened and medicated while out-of-area or when the assigned dentist is unavailable to render care.
12. The treatment of congenital and/or developmental malformations, which includes the treatment of congenitally missing and extra, supernumerary teeth and related pathology is not covered.
13. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms, and dysplasias is not covered.
14. Dental ridge augmentation, vestibuloplasties, and the excision of benign hyperplastic tissue are not covered.

Your Dental Benefits

15. Prescription drugs and over-the-counter medicines are not covered.
16. Any dental procedure unable to be performed in the Member's Assigned Dental Provider Group because of the Member's general health and physical limitations is not covered unless an alternative is recommended by the Assigned Dental Provider Group and the Member's physician and authorized by the Plan.
17. Oral surgery and procedures performed in connection with orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fiberotomy, gingivectomy, and surgery to uncover impacted teeth are not covered.
18. Services rendered by a dental office other than the Member's Assigned Dental Provider Group are not covered. An exception is made for Emergency Dental Care, as defined in this *Combined Evidence of Coverage and Disclosure Form*.
19. The placement, maintenance, and removal of implants, or crowns and fixed prosthetics supported by implants, are not covered.
20. Restorations to replace or stabilize tooth structure lost solely by abrasion or erosion are not covered. Restorations of natural teeth other than those noted herein are not covered. Such treatment includes, but is not limited to, replacing or stabilizing tooth structure loss by abrasion or erosion.
21. Periodontal splinting/grafting is not covered.
22. Amalgam restorations, with new reiterations of a different material solely to eliminate the presence of amalgam are not covered.
23. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion, alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofascial pain syndrome are not Covered Services. If performed, the patient must pay the dentist's Billed Charges. These services include:
 - Realignment of teeth
 - Gnathologic recording
 - Equilibration
 - Occlusal splints and night guards
 - Overlays, implant supported partial dentures and overdentures
 - The replacement of otherwise serviceable existing restorations and dental prosthetics
 - Precision attachments and stressbreakers
24. Dental services that the Plan or Participating Provider determines not to be medically necessary or consistent with good professional practice are not covered.
25. Dental services that would not be consistent with the individual Member's dental needs and/or professional recognized standards of dental therapeutics for that Member are not covered.
26. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce the likelihood of needing a more invasive surgery and/or experiencing post-operative complications.
27. Adjunctive dental services that are performed solely to facilitate the performance of another non-Covered Service.
28. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaws or related joints are not covered. Requests for such services should be submitted to the Member's full service medical health plan.
29. Relative analgesia (N₂O₂ - nitrous oxide) is not covered.

6. Payment Responsibility

WHAT ARE PREMIUMS? (Prepayment Fees)

Dental Plan Premiums are fees your Employer Group pays to cover the basic costs of your Dental Plan. An Employer Group usually pays these Dental Plan premiums on a monthly basis. Often, the Member shares the cost of these premiums with payroll deductions. Contact your Employer Group's health benefits representative if you have questions about the amount, method and frequency of this contribution.

During the contract year, we will not increase Dental Plan Premiums unless we have delivered a written notice to your Employer Group not less than 30 days prior to the effective date of the change.

WHAT ARE COPAYMENTS? (Other Charges)

In addition to the Dental Plan Premium, you may be responsible for paying a charge when you receive a Covered Service. This charge is called a Copayment. Other procedures do not require a Copayment and are listed in the *Schedule of Benefits* as "\$0", No Charge. If you review your *Schedule of Benefits*, you'll see that the amount of the Copayment depends on the service. A list of Covered Services and their Copayments are set forth in the *Schedule of Benefits*. If you need assistance understanding your *Schedule of Benefits*, or need a new copy, please call our Customer Service Department.

IF YOU GET A BILL (Reimbursement Provisions)

Your Assigned Dental Provider Group will bill you for services that are not covered by this Dental Plan. If you are billed for a Covered Service by your Assigned Dental Provider Group, and you feel this billing is in error, you should do the following:

1. Call the Assigned Dental Provider Group to let them know you believe you have received a bill in error.
2. If you are unable to resolve this issue, please write to PacifiCare Dental at:

PacifiCare Dental
P.O. Box 25187
Santa Ana, CA 92799-5187

Include your name, your PacifiCare Dental ID number and a brief note. The note should also include the date of service, the nature of the service and the name of the Provider Group who provided your care. No claim form is required. If you need additional assistance, call our Customer Service Department at 1-800-228-3384.

Should PacifiCare Dental pay any fees for services that are the responsibility of the Member, the Member shall reimburse PacifiCare Dental for such payment. Failure to reimburse PacifiCare Dental or reach reasonable accommodations with PacifiCare Dental concerning repayment within 30 days after PacifiCare Dental's request for reimbursement shall be grounds for termination of a Member's membership pursuant to **Section 7. Member Eligibility - Termination for Good Cause**. The exercise of PacifiCare Dental's right to terminate the Member shall not affect the Plan's right to continue enforcement of its right to reimbursement from the Member.

YOUR BILLING PROTECTION

All PacifiCare Dental Members have rights that protect them from being charged for Covered Services in the event PacifiCare Dental fails to pay a Participating Provider, a Participating Provider becomes insolvent, or a Participating Provider breaches its contract with PacifiCare. In none of these instances may the Participating Provider send you a bill, charge you, or have any other recourse against you for a Covered Service. However, this provision does not prohibit the collection of Copayment amounts as outlined in the *Schedule of Benefits*.

In the event of a Participating Provider's insolvency, PacifiCare Dental will continue to arrange for your benefits. If for any reason PacifiCare Dental is unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of PacifiCare Dental insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your PacifiCare Assigned Dental Provider Group. You may, however, be responsible for any properly authorized Covered Services from a Non-Participating Provider or Emergency Services from a Non-Participating Provider.

NOTE: If you receive a bill because a Non-Participating Provider refused to accept payment from PacifiCare Dental, you may submit a claim for reimbursement.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. The following rules are used to determine which plan is primary and which is secondary for payment. The first of the following rules that describes which plan pays its benefits before another plan is the rule that will apply.

- A. A plan that covers the Member as a subscriber or policyholder is primary to a plan that covers the Member as a dependent.
- B. In the case of a child covered as a dependent under both parents' plans and the parents are not separated or divorced, the plan of the parent with the earliest birthday in the year is primary.

Payment Responsibility

- C. If a child of divorced or separated parents is covered as a dependent under the parents' coverage, the respective order of benefit determination is as follows:
 - 1. The plan of the parent to whom a court decree has assigned financial responsibility for the child's health care expenses.
 - 2. The plan of the parent who has custody of the child.
 - 3. The plan of the spouse of the parent who has custody of the child.
 - 4. The plan of the parent not having custody of the child.
- D. The plan that covers a person as an active employee is primary to a plan that covers a person as a laid-off or retired employee.
- E. A plan that provides coverage under a federal or state law right of continuation is secondary to a plan that provides coverage to the Member as a subscriber, policyholder or dependent.
- F. If none of the above rules determine the order of benefits, the plan that has covered the employee the longest is primary.

When the Dental Plan is primary, your Participating Provider is permitted to:

- Submit a bill at Participating Provider's usual and customary rates to the secondary plan, but indicating the PacifiCare Copayment for procedures performed.
- Accept payment of the PacifiCare Copayment amount from the secondary plan.
- Bill the Member only if the secondary plan pays an amount less than the PacifiCare Copayment.

When the Dental Plan is secondary, your Participating Provider is permitted to:

- Bill the primary plan for all procedures at the Participating Provider's usual and customary rates.
- Keep all payments from the primary plan, but must waive the PacifiCare Copayment if the secondary plan's payment exceeds the PacifiCare amount. If the secondary plan pays less than the PacifiCare Copayment, the Participating Provider may collect the difference from the Member.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply COB rules and to determine benefits payable under this Dental Plan and other plans.

PacifiCare Dental may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying COB rules and determining benefits payable under this Dental Plan and other plans covering the person claiming benefits. Each person claiming benefits under this Dental Plan must give PacifiCare Dental any facts it needs to apply those rules and determine benefits payable. PacifiCare Dental may use and disclose a Member's protected dental information for the purposes of carrying out treatment, payment or dental care operations, including but not limited to, diagnoses, payment of dental care services rendered, billing, claims management or other administrative functions of PacifiCare Dental, without obtaining the Member's consent in accordance with state and federal law.

PACIFICARE DENTAL'S RIGHT TO PAY OTHERS

A "payment made" under another plan may include an amount that should have been paid under this Dental Plan. If this happens, PacifiCare Dental may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. PacifiCare Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case, "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the "amount of the payments made" by PacifiCare Dental is more than it should have paid under the COB provision, PacifiCare Dental may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

WORKERS' COMPENSATION

Should any benefit or service be rendered as a result of a Workers' Compensation Injury Claim, the Member shall assign his/her right to reimbursement from other sources to PacifiCare Dental or the Participating Provider who rendered the services. Any reimbursement in excess of the reasonable value of the services performed, subject to Section 3 of the Group Subscriber Agreement, shall be refunded by PacifiCare Dental or the Participating Provider who rendered the services.

PacifiCare Dental will not provide or arrange for benefits, services or supplies required as a result of a work-related injury or illness. This applies to injury or illness resulting from occupational accidents or sickness covered under any of the following: the California Workers' Compensation Act, occupational disease laws, employer's liability or federal, state or municipal law. To recover benefits for a work-related illness or injury, the Member must pursue his or her rights under the Workers' Compensation Act or any other law that may apply to the illness or injury. This includes filing an appeal with the Workers' Compensation Appeals Board, if necessary.

If for any reason PacifiCare Dental provides or arranges for benefits, services or supplies that are otherwise covered under the Workers' Compensation Act, the Member is required to reimburse PacifiCare Dental for the benefits, services or supplies provided or arranged for immediately after receiving a monetary award, whether by settlement or judgment. The Member must also hold any settlement or judgment collected as a result of a Workers' Compensation action in trust for PacifiCare Dental. The amount that must be reimbursed to PacifiCare Dental will be the lesser of the amount the Member recovers or the reasonable value of all services and benefits furnished to him or her or on his or her behalf by PacifiCare Dental for each incident. If the Member receives a settlement from Workers' Compensation coverage that includes payment of future medical costs, the Member must reimburse PacifiCare Dental for any future medical expenses associated with this judgment if PacifiCare Dental covers those services.

When a legitimate dispute exists as to whether an injury or illness is work-related, PacifiCare Dental will provide or arrange for benefits until such dispute is resolved if the Member signs an agreement to reimburse PacifiCare Dental for 100% of the benefits provided.

PacifiCare Dental will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provision of law under the Workers' Compensation Act. Benefits will not be denied to a Member whose Employer has not complied with the laws and regulations governing Workers' Compensation Insurance, provided that such Member has sought and received Covered Services in accordance with this Dental Plan.

THIRD PARTY LIABILITY—EXPENSES INCURRED DUE TO LIABLE THIRD PARTIES ARE NOT COVERED

Dental care expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, liable third party) is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Dental Plan. Liability insurance cases: Dental care that is covered under automobile, medical, no-fault or similar type is also excluded from coverage under this Dental Plan. However, in all cases, PacifiCare Dental will pay for the arrangement or provision of dental services for a Member that would have been Covered Services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the Section of the *Combined Evidence of Coverage and Disclosure Form* captioned "PacifiCare Dental's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Dental Expenses."

PACIFICARE DENTAL'S RIGHT TO THE REPAYMENT OF A DEBT AS A CHARGE AGAINST RECOVERIES FROM THIRD PARTIES LIABLE FOR A MEMBER'S DENTAL EXPENSES

If a Member is injured by a liable third party, the Member agrees to give PacifiCare Dental, or its representative, agent or delegate, a security interest in any money the Member actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

If the Member does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Member will have no obligation to repay the Member's debt to PacifiCare Dental, which debt shall include the cost of arranging or providing otherwise covered dental care services to the Member for the care and treatment that was necessary because of a liable third party.

The security interest the Member grants to PacifiCare Dental, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Member's dental care services for injuries caused by a liable third party.

NON-DUPLICATION OF BENEFITS WITH AUTOMOBILE, ACCIDENT OR LIABILITY COVERAGE

If you are receiving benefits as a result of automobile, accident or liability coverage, PacifiCare Dental will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected, and to notify PacifiCare Dental of such coverage when available. PacifiCare Dental will provide Covered Services over and above your automobile, accident or liability coverage, if the cost of your dental care services exceeds such coverage.

7. Member Eligibility

This section describes how you become a PacifiCare Dental Member. It will also answer other questions about eligibility. In addition, you will learn ways you may be able to extend your PacifiCare Dental coverage when it would otherwise terminate.

WHO IS ELIGIBLE TO RECEIVE BENEFITS UNDER THIS PLAN

There are two kinds of PacifiCare Dental Members: Subscribers and enrolled Dependents. The Subscriber is the person who enrolls through his or her Employer Group-sponsored dental benefit plan. The Employer Group, in turn, has signed a Group Agreement with PacifiCare Dental. Your Employer Group will decide who can participate in this Dental Plan, subject to the coverage terms set out in the contract between PacifiCare Dental and your Employer Group. Should the Plan determine that you or a Dependent no longer meets the coverage terms of the Dental Plan contract, the Plan will inform your Employer Group that you or your Dependent is no longer eligible.

Your eligible Dependents (for purposes of the Dental Plan) may include your Spouse or domestic partner and all children, in accordance with the limitations in the items noted below, who are unmarried and chiefly dependent upon you for support. Your eligible Dependents will also include all newborn infants. Their benefits will begin at the moment of their birth. All adopted, foster and stepchildren will be eligible from the date of their placement with you.

Member Eligibility

The following Dependents are eligible to enroll in PacifiCare Dental:

1. The Subscriber's Spouse;
2. The unmarried biological children of the Subscriber or the Subscriber's Spouse (step-children) who are under the Limiting Age established by the Employer Group (for an explanation of "Limiting Age," see Definitions);
3. Children who are legally adopted or placed for adoption with the Subscriber or the Subscriber's Spouse who are under the Limiting Age established by the Employer Group;
4. Children for whom the Subscriber or the Subscriber's Spouse has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to PacifiCare Dental upon request; and
5. Children for whom the Subscriber or the Subscriber's Spouse is required to provide health insurance coverage pursuant to a Qualified Medical Child Support Order, assignment order, or medical support order.

Your Dependent children cannot be denied enrollment and eligibility due to the following:

- They were born to a single person or unmarried couple;
- They are not claimed as dependents on a Federal Income Tax Return;
- They do not reside with the Subscriber or within the PacifiCare Dental Service Area.

ELIGIBILITY

All Members must meet all eligibility requirements established by the Employer Group and PacifiCare Dental. PacifiCare Dental's eligibility requirements are:

- Have a Primary Residence within California;
- Select an Assigned Dental Provider Group within a 30-mile radius of his or her Primary Residence or Primary Workplace (except children enrolled as a result of a Qualified Medical Child Support Order);
- Meet any other eligibility requirements established by the Employer Group, such as exhaustion of a waiting period before an employee can enroll in PacifiCare Dental. Employers will also establish the Limiting Age, the age limit for providing coverage to unmarried children.

Eligible Dependents must enroll in PacifiCare Dental at the same time as the Subscriber or risk not being eligible to enroll until the Employer Group's next Open Enrollment Period, as explained below. All applicants for coverage must complete and submit to PacifiCare Dental all applications or other forms or statements that PacifiCare Dental may reasonably request.

Enrollment is the completion of a PacifiCare Dental enrollment form (or a non-standard enrollment form approved by PacifiCare Dental) by the Subscriber on his or her own behalf or on the behalf of any eligible Family Member. Enrollment is conditional upon acceptance by PacifiCare Dental, the existence of a valid Employer Group Agreement, and the timely payment of applicable Dental Plan Premiums. PacifiCare Dental may at its discretion, and subject to specific protocols, accept enrollment data through an electronic submission.

Your effective date of enrollment in PacifiCare Dental will depend on when and how you enroll. These circumstances are explained below.

ADDING DEPENDENTS TO YOUR COVERAGE

The Subscriber's Spouse and eligible children may apply for coverage with PacifiCare Dental during the Employer's Open Enrollment Period. If you are declining enrollment for yourself or your dependents (including your Spouse) because of other dental plan or insurance coverage, you may in the future be able to enroll yourself or your dependents in PacifiCare Dental, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other dependents to enroll). Under the following circumstances, new Dependents may be added outside the Open Enrollment Period.

1. **Getting married.** When a new Spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the first day of the month following the date of marriage. An application to enroll a Spouse or child eligible as a result of marriage must be made within 30 days of the marriage.
2. **Newborns.** Newborns are covered for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, the Subscriber must submit an enrollment form to PacifiCare Dental prior to the expiration of the 30-day period.
3. **Adoption or Placement for Adoption.** Adopted children coverage is effective on the date of adoption or placement for adoption. The Subscriber must submit:
 - an adoptive placement form from a recognized county or private agency;
 - as documented by a health facility, a minor release form, a medical authorization form or a relinquishment form, granting you or your Spouse the right to control the health care for the adoptive child;

- in absence of such documents, evidence of the Subscriber's or Spouse's right to control the health care of the child placed for adoption.

An application must be received within 30 days of the adoption placement.

4. **Guardianship.** To enroll a dependent child for whom the Subscriber has assumed legal guardianship, the Subscriber must submit an enrollment form to PacifiCare Dental along with a certified copy of a court order granting guardianship within 30 days of when the Subscriber assumed legal guardianship. Coverage will begin on the first of the month following receipt by PacifiCare Dental of an enrollment form with a copy of the court or administrative order.

LATE ENROLLMENT

In addition to a special enrollment period due to the addition of a new Spouse or child, there are certain circumstances when employees and their dependents may enroll outside of the employer's enrollment period. These circumstances include:

- The eligible employee (on his or her own behalf, or on behalf of any eligible dependents) declines in writing to enroll in PacifiCare Dental when they were first eligible because they had other dental coverage; and
- PacifiCare Dental cannot produce a written declination statement from the Employer Group or eligible employee stating that the eligible employee (on his or her own behalf, or on behalf of any eligible dependents) was provided with and signed an acknowledgment of explicit written notice in boldface type specifying that failure to elect coverage with PacifiCare Dental during the initial enrollment period permits the Plan to impose an exclusion of coverage under the PacifiCare Dental plan for a period of 12 months from the date of election of coverage under the PacifiCare Dental plan, unless the eligible employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.
- The other dental coverage is no longer available due to:
 1. The employee or eligible dependent has exhausted COBRA continuation coverage under another plan;
 2. The termination of employment or reduction in work hours of a person through whom the employee or eligible dependent was covered; or
 3. The termination of the other dental coverage; or
 4. The cessation of an employer's contribution toward the employee or eligible dependent coverage; or
 5. The death, divorce or legal separation of a person through whom the employee or eligible dependent was covered.
- A Court has ordered dental coverage to be provided for your Spouse or minor child.

If the employee or an eligible dependent meets these conditions, the employee must request enrollment with PacifiCare Dental no later than 30 days following the termination of the other dental plan coverage. PacifiCare Dental may require proof of loss of the other coverage. Enrollment will be effective the first day of the calendar month following receipt by PacifiCare Dental of a completed request for enrollment.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Member (or a person otherwise eligible to enroll in PacifiCare Dental) may enroll a child who is eligible to enroll in PacifiCare Dental upon presentation of a request by a District Attorney, State Department of Health Services, or a court order to provide medical support for such a dependent child without regard to any enrollment period restrictions.

A person having legal custody of a child or a custodial parent who is not a PacifiCare Dental Member may ask about obtaining Dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling PacifiCare Dental's Customer Service Department. A copy of the court or administrative order may be required with the enrollment application. Information including, but not limited to, the ID card, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the first of the month following receipt by PacifiCare Dental of an enrollment form with the court or administrative order attached.

Except for Emergency Dental Care, to receive coverage, all care must be provided or arranged in the PacifiCare Dental Service Area by the designated Assigned Dental Provider Group, as selected by the custodial parent or person having legal custody.

CONTINUING COVERAGE FOR STUDENT AND DISABLED DEPENDENTS

Certain Dependents who would otherwise lose coverage under the Dental Plan due to their attainment of the Limiting Age established by the Employer Group may extend their coverage under the following circumstances:

STUDENT DEPENDENTS: An unmarried Dependent who is registered on a full-time basis (at least 12 semester units or the equivalent as determined by PacifiCare Dental) at an accredited school or college may continue as an eligible Dependent through the Limiting Age established by the Employer Group for full-time students, if proof of such status is provided to PacifiCare Dental on a periodic basis. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Service Area with the Subscriber and the student must select an Assigned Dental Provider Group within 30 miles of that address. All dental care coverage must be provided or arranged for in the Service Area by the designated Assigned Dental Provider Group, except for Emergency Dental Services.

Member Eligibility

DISABLED DEPENDENTS: Unmarried enrolled Dependents who attain the Limiting Age established by the Employer Group may continue enrollment in the Dental Plan beyond the Limiting Age if the unmarried Dependent meets all of the following:

1. The unmarried Dependent resides within the Service Area with the Subscriber or the Subscriber's separated or divorced Spouse;
2. The unmarried Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
3. The unmarried Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
4. The unmarried Dependent's mental or physical condition existed continuously prior to reaching the Limiting Age.

In order to continue coverage under this section for qualifying disabled Dependents, proof of such disability and dependency must be provided to PacifiCare Dental by the Member within 31 days of the onset of the disability, attainment of the Limiting Age, or at the time of the Subscriber's initial enrollment in PacifiCare Dental.

PacifiCare Dental may require ongoing proof of a Dependent's disability and dependency, but not more frequently than annually after the 2-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 mental retardation or physical handicap.

It is your responsibility (and the responsibility of your Employer Group) to keep us advised of changes that affect each Dependent's status. To add, delete, or change Dependent status, please contact your Employer Group.

Please note that delay in providing the information requested above may result in your Employer Group determining your Dependent is no longer eligible. A Dependent who is no longer eligible may in some cases be eligible for continuation of benefits pursuant to Cal-COBRA or COBRA. Please refer to the "If You Lose Your Eligibility for Group Dental Benefits (Continuation of Benefits)" section.

RENEWAL PROVISIONS

We have contracted with your Group or Employer Group to provide this dental plan for a period of 1 year. After that, the contract will automatically renew for another year, without changes, unless PacifiCare Dental or the Group decides to change the benefits, at least 60 days before the renewal date, or unless the contract is terminated by your Employer Group or PacifiCare under applicable law or terms of the contract.

During the contract year, we will not increase your monthly rate, nor will we decrease your benefits, unless we have delivered a written notice to your Employer Group not less than 30 days prior to the effective date of the change.

ENDING COVERAGE (TERMINATION OF BENEFITS)

Usually, your enrollment in PacifiCare Dental terminates when the Subscriber or enrolled Dependent is no longer eligible for coverage under the Employer Group's dental benefit plan. In most instances, your Employer Group determines the date in which coverage will terminate.

Continuing coverage under this Dental Plan is subject to the terms and conditions of the Employer's Group Agreement with PacifiCare Dental.

When the Group Agreement between the Employer Group and PacifiCare Dental is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by PacifiCare Dental for non-payment of Premiums, coverage for all Members covered under the Group Agreement will be terminated effective the last day for which Dental Plan Premiums were received. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated for any reason, including the non-payment of Dental Plan Premiums. PacifiCare Dental is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

In addition to terminating the Group Agreement, PacifiCare Dental may terminate a Member's coverage for any of the following reasons:

- The Member no longer meets the eligibility requirements established by the Employer Group and/or PacifiCare Dental.
- The Member establishes his or her Primary Residence outside the State of California.
- The Member establishes his or her Primary Residence outside the PacifiCare Dental Service Area and does not work inside the PacifiCare Dental Service Area (except for a child subject to a qualified child medical support order; for more information, refer to "Qualified Medical Child Support Order" in this section).

TERMINATION FOR GOOD CAUSE

PacifiCare Dental has the right to terminate or not renew your coverage under this dental Plan in the following situations:

- **Failure to Pay.** Your coverage may be terminated or not renewed if you fail to pay any required Copayments, coinsurance or charges owed to a Provider or PacifiCare Dental for Covered Services. To be subject to termination or non-renewal under this provision, you must have been billed by the Provider for two different billing cycles and have failed to pay or make appropriate payment arrangements with the Provider. PacifiCare Dental will send you written notice, and you will be subject to termination if you do not pay or make appropriate payment arrangements within the 30-day notice period.

- **Fraud or Misrepresentation.** Your coverage may be terminated or not renewed if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form or fraudulently or deceptively use services or facilities of PacifiCare Dental, its Participating Providers or other dental care Providers (or knowingly allow another person to do the same), including altering a prescription. Termination is effective immediately on the date PacifiCare Dental mails the notice of termination, unless PacifiCare Dental has specified a later date in that notice.
- **Disruptive Behavior.** Your coverage may be terminated if you threaten the safety of Plan employees, Providers, Members or other patients, or your repeated behavior has substantially impaired PacifiCare Dental's ability to furnish or arrange services for you or other Members, or substantially impaired a Provider(s) ability to provide services to other patients. Termination is effective 15 days after the notice is mailed to the Subscriber.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the PacifiCare Dental or COBRA of Cal-COBRA Plan and lose the right to re-enroll in PacifiCare Dental in the future. **Under no circumstances will a Member be terminated due to health status or the need for dental care services.** Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information contact our Customer Service Department.

NOTE: If a Group Agreement is terminated by PacifiCare Dental, reinstatement with PacifiCare Dental is subject to all terms and conditions of the Group Agreement between PacifiCare Dental and the Employer Group.

ENDING COVERAGE: SPECIAL CIRCUMSTANCES FOR ENROLLED DEPENDENTS

Enrolled Dependents terminate on the same date of termination as the Subscriber. If there's a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they marry or reach the Limiting Age established by the Employer Group and do not qualify for extended coverage as a student Dependent or as a disabled Dependent. Please refer to the section "*Continuing Coverage for Student and Disabled Dependents*." It may also end when a qualified student reaches the Limiting Age. Please refer to the section below "*If You Lose Your Eligibility for Group Dental Benefits*" for additional coverage that may be available to you.

CANCELLATION OF THE GROUP CONTRACT FOR NONPAYMENT OF PREMIUMS

If the Group Contract is terminated by PacifiCare Dental for non-payment of premiums when due, coverage for all Members covered under the Group Contract will be terminated effective the last day for which premiums were paid, subject to compliance with notice requirements. This period will not exceed the 60 days before the date the Plan mails you the Notice Confirming Termination of Coverage.

PacifiCare Dental will mail your Employer a notice at least 15 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your Employer regarding the consequences of your Employer's failure to pay the premiums due within 15 days of the date the notice was mailed.

If payment is not received from your Employer within 15 days of the date the Prospective Notice of Cancellation is mailed, PacifiCare Dental will cancel the Group Contract and mail you a Notice Confirming Termination of Coverage, which will provide you with the following information:

- That the Group Contract has been cancelled for non-payment of premiums.
- The specific date and time when your Group coverage ended.
- The Plan telephone number you can call to obtain additional information, including whether your Employer obtained reinstatement of the Group Contract. This confirmation of reinstatement will be available on request 16 days after the date the Notice Confirming Termination of Coverage is mailed.
- An explanation of your options to purchase continuation coverage, including coverage effective as of the termination date so you can avoid a break in coverage, and the deadline by which you must elect to purchase such continuation coverage, which will be 31 days after the date the Plan mails you the Notice Confirming Termination of Coverage.

REINSTATEMENT OF THE CONTRACT AFTER CANCELLATION

If the Group Contract is cancelled for the Group's nonpayment of premiums, the Plan will permit reinstatement of the Group Contract once during any 12-month period if the Group pays the amounts owed within 15 days of the date the Plan mails the Notice Confirming Termination.

IF YOU LOSE YOUR ELIGIBILITY FOR GROUP DENTAL BENEFITS (CONTINUATION OF BENEFITS)

Depending on the size of your Employer, you may also be eligible for continuation of your group dental benefits under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or the California Continuation Benefits Replacement Act (Cal-COBRA). Please refer to the section below for information regarding COBRA and Cal-COBRA. Also contact your Employer Group or its COBRA/Cal-COBRA administrator for more information.

If your Spouse loses eligibility due to your death or divorce, he or she will have the same opportunity to continue group dental plan benefits that you had. Your spouse may also be entitled to continuation of your group dental benefits under COBRA or Cal-COBRA. Again, you should ask your Employer Group for more information.

Member Eligibility

If your Employer Group or Employer has determined you are ineligible for coverage, we offer a prepaid dental plan for individuals who are not eligible for Employer Group or Employer dental plan benefits. Individual dental benefits are different from group dental benefits. You should call our Customer Service Department for more information.

FEDERAL COBRA CONTINUATION COVERAGE

If the Subscriber's Employer Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), you may be entitled to temporarily extend your coverage under the Dental Plan at group rates, plus an administration fee, in certain instances where your coverage under the Dental Plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of COBRA continuation coverage.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of group Dental Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent children could become qualified beneficiaries if coverage under the group Dental Plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Please consult with your Employer Group regarding any applicable premiums.

If you are a Subscriber covered by this Dental Plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because either of the following qualifying events happens:

- Your hours of employment are reduced to less than the number of hours required for eligibility, or
- Your employment ends for any reason other than gross misconduct on your part.

If you are the Spouse of a Subscriber covered by this Dental Plan, you have the right to choose COBRA continuation coverage for yourself if you lose group health coverage under this Dental Plan because any of the following qualifying events happens:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced to less than the number of hours required for eligibility;
3. Spouse's employment ends (for reasons other than his or her gross misconduct);
4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

In the case of a Dependent child of a Subscriber enrolled in this Dental Plan, he or she has the right to continuation coverage if group health coverage under this Dental Plan is lost because any of the following qualifying events happens:

1. The Subscriber dies;
2. The Subscriber's hours of employment are reduced to less than the number of hours required for eligibility;
3. Subscriber's employment ends (for reasons other than his or her gross misconduct);
4. The Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The Subscriber's become divorced or legally separated; or
6. The Dependent child ceases to be a Dependent eligible for coverage under this Dental Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

Your Employer Group (or, if applicable, its COBRA administrator) will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer Group must notify its COBRA administrator of the qualifying event. (Similar rights may apply to certain retirees, Spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage.)

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the Subscriber or a Dependent child losing eligibility for coverage as a Dependent child under the Dental Plan), the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) within 60 days after the qualifying event occurs. Please consult your Employer Group regarding its plan procedures for providing notice of qualifying events.

HOW IS COBRA COVERAGE PROVIDED?

Once your Employer Group (or, if applicable, its COBRA administrator) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered by the Employer Group (or its COBRA administrator) to each of the qualified beneficiaries. Under federal law, you must be given at least 60 days to elect COBRA continuation coverage. The 60-day election period is measured from the later of:

1. the date coverage ends due to a qualifying event; or
2. the date you receive the election notice provided by your Employer Group (or its COBRA administrator).

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Subscribers covered by this Dental Plan may elect COBRA continuation coverage on behalf of their Spouses; and parents or legal guardians may elect COBRA continuation coverage on behalf of Dependent children. **If you do not choose COBRA continuation coverage on a timely basis, your group health insurance coverage under this Dental Plan will end.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Subscriber, the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), the Subscriber's divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child under this Dental Plan, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or any of your Family Members covered under this Dental Plan is determined by the Social Security Administration to be disabled and you notify your Employer Group (or, if applicable, its COBRA administrator) in a timely fashion, you and your entire Family Members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please consult your Employer Group regarding their plan procedures for providing notice of disability.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If a Family Member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to your Employer Group (or, if applicable, COBRA administrator). This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under this Dental Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under this Dental Plan had the first qualifying event not occurred.

Please contact your Employer Group (or, if applicable, its COBRA administrator) for more information regarding the applicable length of COBRA continuation coverage available.

COBRA MAY TERMINATE BEFORE MAXIMUM COVERAGE PERIOD ENDS.

Under COBRA, the continuation coverage may terminate before the maximum coverage period if any of the following events occur:

1. Your Employer Group no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group Dental Plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

COBRA PREMIUM

Under the law, you may have to pay all of the premium for your continuation coverage. The Premium for COBRA continuation coverage is generally 102% of the applicable Dental Plan Premium. However, if you are on a disability extension, your cost will be 150% of the applicable Premium. You are responsible for the timely submission of the COBRA premium to the Employer Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to PacifiCare Dental.

Member Eligibility

IF YOU HAVE QUESTIONS ABOUT COBRA

If you have any questions about your COBRA continuation coverage rights, please contact your Employer Group.

CAL-COBRA CONTINUATION COVERAGE

If the Subscriber's Employer Group is subject to the California Continuation Benefits Replacement Act (Cal-COBRA), you may be entitled to temporarily extend your coverage for up to 36 months, based upon 110% of your former Employer's group plan rates in certain instances where your coverage under the Dental Plan would otherwise end. In the case of a Subscriber who is determined to be disabled under the Social Security Act, the Subscriber will pay 150% of the former Employer's group plan rate after the first 18 months of continuation coverage and up to the month in which the Subscriber becomes entitled to Medicare, but not to exceed 36 months.

Cal-COBRA only applies when Subscriber's former Employer has 2 to 19 eligible employees who are not covered or eligible for federal COBRA coverage. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under Cal-COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under Cal-COBRA. If your former Employer Group later qualifies for federal COBRA benefits and coverage, once you are enrolled on Cal-COBRA, your benefits will continue under Cal-COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of Cal-COBRA continuation coverage.

CAL-COBRA QUALIFYING EVENTS FOR SUBSCRIBERS

If you are a Subscriber covered by this Dental Plan, you have a right to choose Cal-COBRA continuation coverage if you lose your group coverage because of one the following initial qualifying events:

1. The termination of your employment (for reasons other than gross misconduct on your part); or
2. The number of hours you actually work on a weekly basis are cut back to less than the number of hours required for continued group plan eligibility, as determined by your Employer.

Additionally, if you are determined to be disabled under Title II or Title XVI of the United States Social Security Act within 60 days of your initial qualifying event, you must notify your former Employer of this determination within 60 days of the date of the determination letter and prior to the 36th month of Cal-COBRA coverage. You are required to pay to PacifiCare Dental 150% of the group rate after the first 18 months and up to the month in which you become entitled to Medicare, but not to exceed a combined total of 36 months. Your coverage under Cal-COBRA will end upon your Medicare entitlement. In the event the Social Security Administration determines that you are no longer disabled, you have 30 days from the date of the determination letter to contact PacifiCare of this decision. Your termination date will be the later of 36 months from the date of your initial qualifying event or the first of the month following 31 days from the date of the final Social Security Administration determination.

CAL-COBRA QUALIFYING EVENTS FOR SPOUSES

If you are the Spouse of a Subscriber covered by this Dental Plan, you have the right to choose Cal-COBRA continuation coverage for up to 36 months based upon 110% of the Subscriber's former Employer's group plan rates for yourself if you lose group coverage under this Dental Plan for any of the following four reasons (also called a qualifying event):

1. The death of the Subscriber;
2. A termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in the Subscriber's number of hours actually worked to less than the number of hours required for continued group plan eligibility, as determined by the Employer;
3. Divorce or legal separation from the Subscriber; or
4. The Subscriber becomes entitled to Medicare. (In the case of a Subscriber who is determined to be disabled under the Social Security Act, the spouse will pay 110% of the former employer's health plan group rate after the first 18 months of continuation coverage and up to 36 months. In the case of a Subscriber who becomes entitled to Medicare and voluntarily terminates his or her group plan coverage, the spouse may have up to 36 months based upon 110% of the Subscriber's former Employer's group plan rates.)

CAL-COBRA QUALIFYING EVENTS FOR DEPENDENT CHILDREN

In the case of a Dependent child of a Subscriber enrolled in this Dental Plan, he or she has the right to continuation coverage for up to 36 months based upon 110% of the Subscriber's former Employer's group plan rates if group coverage under this Dental Plan is lost for any of the following five reasons (also called a qualifying event):

1. The death of the Subscriber;
2. A termination of the Subscriber's employment (for reasons other than gross misconduct), or the number of the Subscriber's hours is cut back to less than the number of hours required for continued group plan eligibility, as determined by the Employer;
3. The Subscriber's divorce or legal separation;

4. The Subscriber becomes entitled to Medicare; (In the case of a Subscriber who is determined to be disabled under the Social Security Act, the dependent will pay 110% of the former Employer's group plan rate after the first 18 months of continuation coverage and up to 36 months. In the case of a Subscriber who becomes entitled to Medicare and voluntarily terminates his or her group plan coverage, the dependent may have up to 36 months based upon 110% of the Subscriber's former Employer's group plan rates.); or
5. The Dependent child ceases to be a Dependent eligible for coverage under this Dental Plan.

CAL-COBRA NOTIFICATION OF QUALIFYING EVENTS

Under Cal-COBRA, as a condition of receiving Cal-COBRA benefits, the Member must provide PacifiCare Dental with written notification of the occurrence of the following qualifying events within 60 days of the occurrence of the event:

1. The Subscriber's death;
2. Divorce or legal separation;
3. The loss of Dependent status; or
4. The covered employee's entitlement to Medicare.

CAL-COBRA ENROLLMENT AND PREMIUM INFORMATION

It is your responsibility to notify PacifiCare Dental of the occurrence of any of the above qualifying events within 60 days, except that your Employer must notify PacifiCare Dental within 30 days of the occurrence of a termination of employment or a reduction in the number of hours you actually work on a weekly basis to less than the number of hours required for continued group plan eligibility, as determined by your Employer, which would result in loss of coverage under your group benefit plan. Your failure to notify PacifiCare Dental of the occurrence of a qualifying event within 60 days will disqualify you from receiving continuation coverage.

Members may contact PacifiCare Dental for a copy of the Qualifying Event Notification Form that should be used to notify the Plan. All notifications must be submitted to PacifiCare Dental in writing at the following address:

PacifiCare Dental
Membership Accounting
P.O. Box 25187
Santa Ana, CA 92799-5187

Within 14 days of receiving written notice of a qualifying event, PacifiCare Dental will send Cal-COBRA enrollment and premium information to you. A Member who wishes to elect Cal-COBRA continuation coverage must request the continuation coverage in writing and deliver the written request, by first-class mail, or other reliable means of delivery, to PacifiCare within the 60-day period following the later of:

1. The date that the Member's coverage under the Group Agreement terminated or will terminate by reason of the qualifying event; or
2. The date the enrollee was sent Cal-COBRA enrollment and premium information.

Failure to elect Cal-COBRA coverage within the 60-day period will disqualify the Member from Cal-COBRA coverage.

If you do not choose continuation coverage on a timely basis, your group insurance coverage under this Dental Plan will end and you will be financially responsible for any dental services that you have received after your terminating event.

If you choose continuation coverage, your former Employer Group is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated eligible employees or family members. Cal-COBRA permits you to maintain continuation coverage for up to 36 months. If the Social Security Administration determines you to be disabled at any time during the first 60 days of Cal-COBRA, Cal-COBRA allows you to maintain continuation coverage up to your Medicare entitlement, but not to exceed a combined total of 36 months. Please contact your Employer Group or PacifiCare for more information regarding Cal-COBRA continuation coverage.

A child who is born to or placed for adoption with the eligible Subscriber during a period of Cal-COBRA continuation coverage will also be eligible to enroll as a Cal-COBRA qualified beneficiary. These Cal-COBRA qualified beneficiaries can be added to your Cal-COBRA continuation coverage upon proper notification to PacifiCare of the birth or adoption. Please call PacifiCare at 1-800-228-3384 to start the enrollment process of your new child. A Change Form will be mailed to you along with your new premium information. The Change Form must be received within 30 days of the child's birth or placement for adoption.

TERMINATION OF CAL-COBRA CONTINUATION COVERAGE

However, under Cal-COBRA, the continuation coverage may be cut short for any of the following four reasons:

1. Your former Employer Group no longer provides group coverage to any of its Eligible Employees;
2. The premium for continuation coverage is not paid on time;

Member Eligibility

3. The qualified beneficiary becomes covered after the date he or she elects Cal-COBRA continuation coverage under another group plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have; or
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects Cal-COBRA continuation coverage.

For Cal-COBRA, you are responsible for paying the Dental Plan Premium directly to PacifiCare Dental on a monthly basis and must deliver it by first-class mail or other reliable means. The first month's Cal-COBRA Dental Plan Premium payment is due within 45 days of the date that you submit the Cal-COBRA election form to the Plan. This payment must be sufficient to pay all premiums due from the first month after the qualifying event through the current month. Failure to submit the correct premium amount will disqualify you from receiving Cal-COBRA continuation coverage. Thereafter, Cal-COBRA premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). Your Cal-COBRA premium will generally be 110% of the premium charged to your employer for similarly active employees. Your premium may be increased or your benefits decreased each time your former Employer's group benefit package renews or changes. Please note you will not be enrolled in Cal-COBRA until PacifiCare Dental receives both your Cal-COBRA election form and your first Cal-COBRA premium payment. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the Medicare entitled qualified beneficiary is required to pay to PacifiCare 150% of the group rate after the first 18 months of continuation coverage and up to the month in which they become Medicare entitled, but not to exceed 36 months.

If the contract between the Subscriber's Employer Group and PacifiCare Dental terminates prior to the date your continuation coverage would terminate under Cal-COBRA, you may elect continuation coverage under the subsequent benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan. However, continuation coverage will terminate if you fail to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

If you have any questions about Cal-COBRA, please contact PacifiCare Dental or your former Employer Group.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Continuation coverage under this Dental Plan may be available to you through your Employer Group under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Dental Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA. Your Employer Group will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must select a Participating Provider within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area by the designated Participating Provider, except for Emergency and Urgently Needed Services.

The Dental Plan Premium for USERRA Continuation of benefits is the same as the Dental Plan Premium for other PacifiCare Dental Members enrolled through your Employer Group plus a two percent additional surcharge or administrative fee, not to exceed 102 percent of your Employer Group's active group Premium. Your Employer Group is responsible for billing and collecting Dental Plan Premiums from you or your Dependents and will forward your Dental Plan Premiums to PacifiCare Dental along with your Employer Group's Dental Plan Premiums otherwise due under this Agreement. Additionally, your Employer Group is responsible to maintain accurate records regarding USERRA continuation Member Dental Plan Premium, qualify events, terminating events and any other information that may be necessary for PacifiCare Dental to administer this continuation benefit.

8. Complaints, Disputes and Arbitration

In this section you will find out what to do if you're having a problem with your dental care plan, including how to appeal a dental care decision by PacifiCare Dental or one of our Participating Providers. You'll learn the process that's available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

WHAT IF YOU HAVE A PROBLEM

PacifiCare Dental's top priority is meeting its customers' needs, and that means providing responsive service. If you ever have a question or problem, your first step is to call our Customer Service Department at 1-800-228-3384 (1-877-735-2929 TTY/TDD). A Customer Service representative will make every effort to assist you and attempt to find a resolution to your situation.

If you feel that we haven't assisted you or that your situation requires additional action, you may also request a formal appeal or quality review. To learn more about this, read the following section, *"Appealing a Dental Care Decision."*

APPEALING A DENTAL CARE DECISION

Our appeals and quality-of-care review procedures are designed to deliver a timely response and resolution to your complaints. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the complaint. You may submit a formal appeal within 180 days of your receipt of an initial determination through our Grievances and Appeals Department. To initiate an appeal or request a quality-of-care review, call our Customer Service Department at 1-800-228-3384, where a Customer Service representative will document your oral appeal. You may also file an appeal using the Online Grievance form at www.pacificare-dental.com or write to the Grievances and Appeals Department:

PacifiCare Dental – M/S LC05-293
P.O. Box 25187
Santa Ana, CA 92799-5187
1-800-228-3384

This action will initiate the following Appeals Process (except in the case of Expedited Review as discussed below). You may submit written comments, documents, records and any other information relating to your appeal. PacifiCare Dental will review your appeal, and if the appeal involves a clinical issue, the necessity of treatment, or the type of treatment or level of care proposed or utilized, the determination will be made by a dental reviewer who has the education, training and relevant expertise in the field of dentistry necessary to evaluate the specific clinical issues that serve as the basis of your appeal.

Individuals covered under the Employee Retirement Income Security Act (ERISA), under certain circumstances following an adverse benefit determination, may be eligible to bring a civil action under section 502(a) of ERISA. An ERISA member may obtain, free of charge, any documents, records and other information relevant to his or her appeal by contacting (714) 513-6349.

APPEALS PROCESS

Our Grievances and Appeals Department will acknowledge receipt of your complaint within 5 calendar days, review it, and make a determination within a reasonable period of time appropriate to the dental circumstances, but no later than 30 calendar days after PacifiCare Dental's receipt of the complaint. For determinations denying dental services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage.

All complaints that involve quality-of-care issues are referred to PacifiCare Dental's Grievances and Appeals Department for review. Complaints that affect a Member's immediate condition will receive immediate review. PacifiCare Dental will investigate the complaint, consult with Member's Assigned Dental Provider Group and any other PacifiCare Dental departments and review dental records as necessary. You may need to sign an authorization to release your dental records from any Non-Participating Provider.

Upon completion of the review, but no later than 30 days from PacifiCare Dental's receipt of the complaint, the Member will be notified of the Plan's determination. The results of the quality-of-care review are confidential.

If a Member has asserted a claim for benefits or reimbursement as part of a quality-of-care complaint, the claim for benefits or reimbursement will be reviewed through the appeals process described previously.

EXPEDITED REVIEW

Appeals involving an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb, or major bodily function will be immediately referred to PacifiCare Dental's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeals process. If your appeal requires expedited review, PacifiCare Dental will immediately inform you in writing of your review status and your right to notify the Department of Managed Health Care of the grievance, and will provide you and the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than 3 calendar days from receipt of the grievance.

VOLUNTARY MEDIATION AND BINDING ARBITRATION

If the Member is dissatisfied with PacifiCare Dental's appeals process determination, the Member may request that PacifiCare Dental submit the appeal to voluntary mediation and/or binding arbitration before Judicial Arbitration and Mediation Services, Inc. (JAMS).

Complaints, Disputes and Arbitration

1. **Voluntary Mediation** – In order to initiate mediation, the Member or the agent acting on behalf of the Member shall submit a written request to PacifiCare Dental for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with its JAMS Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.
2. **Binding Arbitration** - Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), except for claims subject to ERISA, between Member (including any heirs or assigns) and PacifiCare Dental, or any of its parents, subsidiaries or affiliates (collectively, "PacifiCare Entities"), shall be submitted to binding arbitration; however, in the event the amount in controversy in the dispute including any claims of damage is not greater than \$5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than \$5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. Member and PacifiCare Entities are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in the county in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by federal and California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, PacifiCare Entities may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. Please contact PacifiCare Dental for more information on how to obtain a hardship application. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking more than \$5,000.00 in damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

BY ENROLLING IN PACIFICARE DENTAL BOTH MEMBER (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

"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 **1-800-228-3384** 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."

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) RIGHTS

The following is a general description of the claims procedures applicable to Employer Groups subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). Members should contact their Employer Group's benefit administrator to determine whether the Employer Group is subject to ERISA.

1. A description of PacifiCare Dental's claims procedures, including the process for obtaining Pre-authorization of a Covered Service, is set forth in this *Combined Evidence of Coverage and Disclosure Form*.
2. PacifiCare Dental or its Participating Provider processes initial requests from Members (or their authorized representatives) for Covered Services pursuant to the following time frames:
 - a. **Non-Urgent Pre-Service Requests.** Members will be notified of decisions to authorize or deny requests for Covered Services within a reasonable period of time appropriate to the medical condition of the Member but not later than 15 days from the receipt of the request. PacifiCare Dental or its Participating Provider may extend the initial time frame for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Member's failure to submit the information

necessary for PacifiCare Dental or its Participating Provider to make a decision regarding the request, the Member will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is received by the Member until the date on which (1) the Member responds with the specified information or (2) the end of the period of time provided to submit the specified information, whichever is earlier.

- b. **Urgent Requests.** A request for Covered Services will be treated as an “urgent request” if making a determination pursuant to the time frames in Section (a) above (i) could seriously jeopardize the life or health of the Member, or (ii) if in the opinion of a Physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. In the event of an urgent request, PacifiCare Dental or its Participating Provider will notify the Member of its determination to authorize or deny as soon as possible, taking into account the Member’s medical condition, but not later than 72 hours after receipt of the urgent request. In the event PacifiCare Dental or its Participating Provider does not have the information necessary to make a decision regarding the request, PacifiCare Dental or its Participating Provider will notify the Member as soon as reasonably possible, but not later than 24 hours after receipt of the request and will inform the Member of the specific information necessary for PacifiCare Dental or its Participating Provider to make a determination regarding the request, and the reasonable time frame (no less than 48 hours) for the Member to provide the specified information. PacifiCare Dental or its Participating Provider will make a determination as soon as possible but no later than 48 hours after the earlier of (1) the receipt of the requested information, or (2) the end of the period of time provided to submit the specified information.
 - c. **Concurrent Care Requests.** If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an “urgent request” as defined in Section (b) above, PacifiCare Dental or its Participating Provider will approve or deny the request as soon as possible, taking into account the Member’s medical condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to PacifiCare Dental or its Participating Provider at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an “urgent request” as defined in Section (b) above, PacifiCare Dental or its Participating Provider will treat the request as a new request for a Covered Service under the Dental Plan and will follow the time frame for non-urgent requests as discussed in Section (a) above.
 - d. **Post-Service Claim.** Members will be notified of denials (in whole or in part) of an initial post-service claim within a reasonable period of time, but not later than 30 days after receipt of the claim. PacifiCare Dental or its Participating Provider may extend the initial time frame for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Member’s failure to submit the information necessary for PacifiCare Dental or its Participating Provider to make a decision regarding the request, the Member will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is received by the Member until the date on which (1) the Member responds with the specified information or (2) the end of the period of time provided to submit the specified information, whichever is earlier.
3. **Appeal.** Members have up to 180 days following receipt of an adverse determination within which to appeal the determination. Members are entitled to a full and fair appeals process. Members may submit written comments, documents, records and information in support of their appeal. PacifiCare Dental will notify the Member of its decision regarding the appeal no later than:
 - 72 hours for an urgent request
 - 30 days for a non-urgent pre-service request (the denial of an initial request for a service not yet provided)
 - 60 days for a post-service claim (the denial of a claim for services already provided but not yet paid for)
 4. The Member agrees that their Provider will be their authorized representative (pursuant to ERISA) regarding the receipt of approvals of requests for Covered Services for purposes of medical management.
 5. ERISA provides for a maximum of 2 mandatory appeal levels. Members enrolled in employee welfare benefit plans subject to ERISA may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of their claim have been completed and the claim has not been approved.
 6. A Member’s participation in a voluntary appeal level does not effect their legal rights provided under ERISA. Any statute of limitations applicable to pursuing civil action will be tolled during the period of a voluntary level of appeal.
 7. Binding Arbitration of claims, as described in this section of this *Combined Evidence of Coverage and Disclosure Form*, will be limited to claims that are not subject to ERISA.

9. General Information

WHAT SHOULD I DO IF I LOSE OR MISPLACE MY MEMBERSHIP CARD?

If you should lose your card, simply call our Customer Service Department.

DOES PACIFICARE DENTAL OFFER A TRANSLATION SERVICE?

PacifiCare Dental uses a telephone translation service for almost 140 languages and dialects. That is in addition to select Customer Service representatives who are fluent in Spanish.

DOES PACIFICARE OFFER HEARING AND SPEECH IMPAIRED TELEPHONE LINES?

PacifiCare Dental uses a dedicated telephone number for the hearing and speech impaired. This telephone number is 1-877-735-2929.

HOW IS MY COVERAGE PROVIDED UNDER EXTRAORDINARY CIRCUMSTANCES?

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Participating Providers will do their best to provide the dental services you need. Under these extreme conditions, go to the nearest dental provider for Emergency Dental Services. PacifiCare Dental will later provide appropriate reimbursement.

HOW DOES PACIFICARE COMPENSATE ITS DENTAL PROVIDER GROUP?

PacifiCare Dental itself is not a Provider of dental services. PacifiCare Dental typically contracts with independent Providers to provide dental services to its Members. None of the contracting dental Providers or employees are employees or agents of PacifiCare Dental, and neither PacifiCare Dental nor any employee of PacifiCare Dental is an employee or agent of any Participating Provider. Once Providers are contracted, they become PacifiCare Dental Participating Providers. PacifiCare Dental's network of Participating Providers includes individual practitioners, group practices, and facilities.

Most of our Participating Providers receive an agreed-upon monthly payment from PacifiCare Dental to provide Covered Services to Members. The monthly payment may be a fixed dollar amount for each Member or a fixed dollar amount for each Member plus a supplemental payment for certain procedures. This monthly payment plus supplemental payment and the Member's Copayment represent the total compensation for professional services directly performed by the dental Provider and may also cover certain referral services. Other dentists are paid on a percentage of usual and customary fees or a discount fee-for-service basis. PacifiCare Dental does not compensate, nor does it provide any financial bonuses or any other incentives to, its Participating Providers based on their utilization patterns.

ORGAN AND TISSUE DONATION

Transplantation is one of the most remarkable success stories in the history of medicine. It is the only hope for thousands of people suffering from organ failure, or in desperate need of corneas, skin, bone or other tissue. Tragically, the need for donated organs and tissues continues to outpace the supply. Nearly 50,000 Americans are waiting for organ transplants while hundreds of thousands more need tissue transplants. Organ and tissue donation provides each of us with a special opportunity to help others. You can save lives and enable recipients to return to work or lead productive lives and others to see for the first time.

MOST ANYONE CAN BE A DONOR

Almost everyone can be a donor. There is no age limit and the number of donors age 50 or older has increased. If you have concerns about organ donation, speak with your family, doctor, clergy member or friends. Most importantly, get the information you need to make a responsible decision that you and your family support.

BE SURE TO SHARE YOUR DECISION

Sharing your decision to be an organ and tissue donor with your family is as important as making the decision itself. Your organs and tissue will not be donated unless a family member gives consent at the time of your death – even if you have signed your driver's license or a donor card. A simple family conversation will prevent confusion or uncertainty about your wishes.

It is also helpful to document your decision by completing a donor card in the presence of your family and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

HOW CAN I LEARN MORE

- To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562
- Request Donor Information from your local Department of Motor Vehicles (DMV)
- On the Internet, contact
 - ◆ All About Transplantation and Donation at www.transweb.org
 - ◆ Department of Health & Human Services at www.organdonor.gov
- Sign the donor card in your family's presence

- Have your family sign as witnesses and pledge to carry out your wishes
- Keep the card with you at all times where it can be easily found

Remember, even if you have signed something, you must tell your family so they can act on your wishes.

PUBLIC POLICY PARTICIPATION

PacifiCare Dental gives its Members the opportunity to participate in establishing the public policy of the Plan. One-third of PacifiCare Dental's Board of Directors is composed of Plan Members. If you are interested in participating in the establishment of PacifiCare Dental public policy, please call or write our Customer Service Department.

GENERAL PROVISIONS

PacifiCare Dental is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and to Chapter 2 of Title 28 of the California Code of Regulations. Any provision required to be in this contract by either of those statutes will apply to PacifiCare Dental, whether or not it is mentioned here.

This dental plan contract will not take effect until PacifiCare Dental has approved and executed it. The contract is executed in Santa Ana and will be construed under the laws of the State of California. All parties agree that any action relating to this contract will be instituted and prosecuted in the courts of Orange County and each party waives the right to a change of venue.

10. Definitions

PacifiCare Dental is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your *Combined Evidence of Coverage and Disclosure Form*, as well as the *Schedule of Benefits*.

“ACUTE CONDITION” means 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 has a limited duration.

“ASSIGNED DENTAL PROVIDER GROUP” means the dental office contracted with PacifiCare Dental where you and your Dependents are assigned to receive dental benefits.

“BILLED CHARGES” means the Providers usual charge for furnishing treatment, services, or supplies.

“COPAYMENT” means the fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

“COVERED SERVICES” are those dental services that are listed in this *Combined Evidence of Coverage and Disclosure Form* at **Section 5: Your Dental Benefits** and *Schedule of Benefits* when they are diagnosed as necessary for the dental health of a Member in accordance with professionally recognized standards of practice.

“DENTAL PLAN” means the benefit plan as described in this *Combined Evidence of Coverage and Disclosure Form*, the *Schedule of Benefits*, and any supplemental benefit materials.

“DENTAL PLAN PREMIUMS” are amounts established by PacifiCare Dental to be paid to PacifiCare Dental by the Employer Group for providing and continuing enrollment in PacifiCare Dental on behalf of a Subscriber and any enrolled Dependents.

“DEPENDENT” means a Member of a Subscriber's family who is enrolled with PacifiCare after meeting all of the eligibility requirements of the Subscriber's Employer Group and PacifiCare Dental, and for whom applicable Dental Plan Premiums have been received by PacifiCare Dental.

“EMERGENCY DENTAL SERVICES” or **“EMERGENCY DENTAL CARE”** means dental services required to diagnose and treat a dental condition which is manifested by acute symptoms of sufficient severity, including severe pain such that a reasonable person with no special knowledge of dentistry could expect the absence of immediate dental attention to result in placing the Member's health in serious jeopardy, serious impairment to the Member's bodily functions, or serious dysfunction of a bodily organ or part.

“EMPLOYER GROUP, GROUP, OR EMPLOYER” means single employer, labor union, trust, organization or association through which you enrolled for coverage.

“FAMILY MEMBER” means the Subscriber's Spouse and any person related to the Subscriber or Spouse by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with PacifiCare Dental, meets all the eligibility requirements of the Subscriber's Employer Group and PacifiCare Dental, and for whom premiums have been received by PacifiCare Dental. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and PacifiCare Dental.

“GROUP AGREEMENT or GROUP CONTRACT” means the Group Subscriber Agreement entered into between PacifiCare Dental and the Employer Group.

“LIMITING AGE” means the age established by your Employer Group when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage.

Definitions

“LABORATORY COST(S)” means the cost for a service that is a dental laboratory upgrade of a standard Covered Service. For such laboratory upgrades, Members are responsible for an additional charge, which is limited to the extra Laboratory Cost incurred by the dentist for the upgrade.

“MEMBER” is any Subscriber or Dependent.

“N2O2” means Nitrous Oxide.

“NON-PARTICIPATING PROVIDER” means a Provider that has not entered into a written agreement to provide Covered Services to PacifiCare Dental’s Members.

“OPEN ENROLLMENT PERIOD” means the time period determined by PacifiCare Dental and the Subscriber’s Employer Group when all eligible employees and their eligible Family Members may enroll in PacifiCare Dental.

“PARTICIPATING PROVIDER” means a Provider that has entered into a written agreement to provide Covered Services to PacifiCare Dental’s Members.

“PLAN” means PacifiCare Dental.

“PRIMARY RESIDENCE” means the home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without intent to return; (2) the Member is absent from the residence for 90 consecutive days; or (3) the Member is absent from the residence for more than 100 days in any 6-month period.

“PRIMARY WORKPLACE” means the facility or location where the Member works most of the time and to which the Member regularly commutes. If the Member does not regularly commute to one location, then the Member does not have a Primary Workplace.

“PROVIDER” means a person, group, facility or other entity that is licensed or otherwise qualified to deliver any of the Covered Services described in this *Combined Evidence of Coverage and Disclosure Form*, the *Schedule of Benefits* and any supplemental benefit materials.

“SCHEDULE OF BENEFITS” means the list of Benefits and Coverages, and the authorized Copayment amounts under the Member’s Dental Plan as set forth in this *Combined Evidence of Coverage and Disclosure Form*.

“SERIOUS CHRONIC CONDITION” means a medical condition due to a disease, illness, or other medical problem or 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.

“SERVICE AREA” means a geographic region in the state of California where PacifiCare Dental is authorized by the California Department of Managed Health Care to provide Covered Services to Members.

“SPECIALIST” means a dentist who has been certified as a dental practice specialist by the appropriate board or authority. Members with PacifiCare Dental’s dental specialty referral benefit may receive services from PacifiCare Dental contracted Specialists in the dental practice fields of endodontics, periodontics, oral surgery or pedodontics if the Member receives a referral from their Assigned Dental Provider Group. PacifiCare Dental’s dental specialty referral benefit does not include referral to prosthodontists.

“SPOUSE” means the Subscriber’s husband or wife who is legally recognized as a husband or wife under the laws of the State of California.

“SUBSCRIBER” means the person enrolled in the dental plan for whom the appropriate dental plan Premiums have been received by PacifiCare Dental and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

“TREATMENT IN PROGRESS” means a dental procedure(s) (as defined by the American Dental Association’s CDT booklet) begun by your treating Participating Provider but not yet completed.

“URGENT DENTAL SERVICES” are those urgently needed services employed to prevent serious deterioration of a Member’s health resulting from an unforeseen dental condition or injury for which treatment cannot be delayed until the Member returns to PacifiCare Dental’s Service Area.

ASK TO SEE *your* TREATMENT PLAN

Sometimes it's difficult to understand exactly what dental treatment you're getting, and why, and how the charges are determined. Dentists are obligated to present all appropriate treatment options, regardless of whether the options are covered by your plan, so it can be confusing when a dentist recommends a treatment that is not covered. Should that occur, remember, there are several things you can do to ensure that you receive appropriate treatment:



1. ASK FOR A TREATMENT PLAN

Regardless of the scope of your treatment, your dental provider should present you with a treatment plan. This plan will normally include:

- An explanation of what services the provider is recommending.
- What treatments your insurance plan covers, and in what amounts.
- An estimate of what charges (if any) you will have to pay.

2. TALK TO YOUR DENTIST DIRECTLY

If you are unsure about either the treatment plan or the charges, never give the go-ahead for treatment without first talking to your dentist. Per the Patient Bill of Rights, as posted by the California Dental Association:

- You have a right to know in advance the type and expected cost of treatment.
- You have a right to ask about treatment alternatives and to be told, in language you can understand, the advantages and disadvantages of each.
- You have a right to ask your dentist to explain all the treatment options regardless of coverage or cost.

3. TALK TO PACIFICARE DENTAL

Member Service representatives are available at 1-800-228-3384 to answer your questions about benefits coverage and charges. They can also locate a dentist who can provide you with a second opinion. And remember — you always have the option of seeing another dentist within your network.

P.O. Box 25187
Santa Ana, CA 92799-5187

Customer Service
1-800-22-TEETH
(1-800-228-3384)

Visit our Web site at www.pacificare-dental.com

This booklet describes your PacifiCare SignatureValue dental plan and includes eligibility information, limitations and exclusions, and other important information. We do encourage all plan members to review this booklet and keep it in a convenient location for future reference.

Should you have questions about your plan, please contact your benefits representative or PacifiCare Dental member service at 1-800-228-3384.