Group

Combined Evidence of Coverage

And

Disclosure Form

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health Plan. The health Plan contract should be consulted to determine the exact terms and conditions of Coverage.

The Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage.

With respect to individual Plan contracts, small group Plan contracts, and any other group Plan contracts for which health care health care services are not negotiated, the applicant has a right to view the Evidence of Coverage and Disclosure Form prior to enrollment.

Upon request, a copy of this Combined Evidence of Coverage and Disclosure Form shall be provided to a non-covered parent having custody of a child.

This Evidence of Coverage and Disclosure Form should be read completely and carefully, and individuals with special health care needs should carefully read those sections that apply to them.

Applicants may receive additional information about the benefits of the Plan by calling (949) 830-1600, Toll-free (877) 4-DENTAL.

The dental health Plan benefits and coverage matrix is located at the end of this Evidence of Coverage and Disclosure Form.

A specimen copy of CDN's contract will be furnished upon request.

WELCOME

California Dental Network, Inc. (CDN) combines comprehensive dental Coverage with a number of cost-saving features for Members and their families. Many preventive procedures are covered at no cost to Members, who will experience significant savings based upon our copayments for covered services. There are no claim forms to complete, and no deductibles or lifetime Benefit maximums.

I. DEFINITIONS

Act means the Knox-Keene Health Care Service Plan Act of 1975 (California Health and Safety Code Sections 1340 et seq.) as amended.

Agreement or Subscriber Agreement means a contract by which its terms limits the eligibility of Subscribers and enrollees to a specified Group. The completed Enrollment Application and Benefit Schedule, under which the Member is enrolled along with the Evidence of Coverage and Disclosure Form, may constitute the entire Agreement.

Benefits or Coverage mean the health care services available under the Subscriber Agreement and/or Benefit Schedule under which a Member is enrolled.

Benefit Schedule means the list of Benefits specifically covered under each Plan denoting the copayments required by the Member.

Capitation means a monthly or annual periodic payment based on a fixed or predetermined basis that is paid to the Provider.

Cobra refers to the Consolidated Omnibus Budget Reconciliation Act of 1986, enacted April 7, 1986.

Copayment means the amount, if any, specified in the Subscriber Agreement, and disclosed in the Evidence of Coverage and Disclosure Form, which represents the Member's portion of the cost of care.

Dependents shall mean the spouse and children of a Member, as defined herein under the section entitled Eligible Dependents.

Emergency Care means service required for immediate alleviation of severe pain or bleeding associated with dental problems and/or immediate diagnosis and treatment of unforeseen dental conditions which, if not immediately diagnosed and treated, may lead to disability, dysfunction or death.

Evidence of Coverage and Disclosure Form means this document issued to the Subscriber or enrollee setting forth the coverage to which the Subscriber or enrollee is entitled.

Exclusion means any provision of this Evidence of Coverage and Disclosure Form whereby Coverage for a specified hazard or condition is not covered by CDN or the Provider.

Group means any employer, labor union or labor management trust fund, or other Subscriber Group.

Limitation means any provision other than an Exclusion which restricts Coverage under the Agreement.

Member shall mean any Subscriber or Dependent who is enrolled under the Agreement and entitled to the Benefits available under the Agreement in return for the payment required to be made to CDN under such Agreement.

Plan is the CDN Plan and shall include those Benefits, Coverage and other charges as set forth herein and in the Benefit Schedule.

Prepayment Fee is the amount paid periodically by the Group for the Subscriber and his or hers enrolled eligible Dependents' coverage under the Subscriber Agreement.

Provider means a licensed California dentist under contract to CDN as a general practitioner, and shall include any hygienists and technicians recognized by the dental profession who assist and act under the supervision of the dentist, and/or a specialist to render services to Members in accordance with the provisions of the CDN Agreement under which a Member is enrolled. The names, locations, hours, services, and other information regarding CDN's Provider facilities may be obtained by contacting CDN's office or the individual Provider.

Regulations means those Regulations promulgated and officially adopted by the California Department of Managed Health Care.

Specialist means a dentist who is responsible for the specific specialized dental care of a Member in one specific field of dentistry, such as endodontics, periodontics, pedodontics, oral surgery or orthodontics, where the Member is referred by CDN.

Subscriber is the person who has entered into an Agreement and who is responsible for payment to CDN or whose employment or other status, except for family dependency, is the basis for eligibility in a CDN Plan.

II. HOW TO USE CDN

In addition to this Evidence of Coverage and Disclosure Form and a Benefit Schedule, CDN issues each Member an Identification Card with the telephone number and address of the selected dental office. Upon request, an identification card will be issued to the non-covered parent having custody of a child. This I.D. Card is to be presented at the time that services are to be rendered by the Provider.

Any applicable waiting period is as specified in the Agreement. If a contract start date is not specified, or there is no Group contract, Coverage always begins on the first day of the month following the date the Member has completed the enrollment material

A complete list of covered services is enclosed in the Benefit Schedule. Most preventive services are provided at no charge to Members, while other procedures require a copayment. Services specifically excluded from Members' Coverage are found in the section titled Exclusions and Limitations. Please read this section carefully. Dental services performed by a non-panel dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Care.

III. ELIGIBILITY

A Member's Group and the Group Subscriber Agreement shall determine the determination of who is eligible to participate and who is actually participating in CDN's Plan. Any disputes or inquiries regarding eligibility, renewal, reinstatement and the like, should be directed to the Member's Group or CDN as appropriate.

IV. ELIGIBLE DEPENDENTS

A Member's eligible Dependents are their lawful spouse and Dependent children. An eligible dependent shall include a) any child born out of wedlock, b) a child not claimed as a dependent on the parents' federal income tax return and c) a child who does not reside with the parent or within the Plan's service area. All newborn infants' Coverage shall commence from and after the moment of birth. Adopted children, stepchildren and foster children shall be covered from and after the date of placement. Except as stated above, Dependents shall be eligible for coverage on the first day of the next month from the date the Subscriber is eligible for coverage, or on the day the Subscriber acquires such Dependent, whichever is later. In a case where a parent is required by a court or administrative order to provide coverage for a child and the parent is eligible for the coverage the Plan shall a) permit the parent to enroll under the Plan any child who is otherwise eligible to enroll for that coverage, without regard to any enrollment period restrictions, b) enroll the child, if parent fails to do so, upon presentation of the court order or request by the district attorney, the other parent or person having custody.

Dependents shall also include all unmarried children under the age of 26 years who are chiefly dependent on the subscriber for support and maintenance. Coverage shall not terminate while a Dependent child is and continues to be:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; ***and***

- Chiefly dependent upon the subscriber for support and maintenance provided the subscriber furnishes proof of such incapacity and dependency to CDN within 31 days of the child attaining the limiting age set forth above, and every two years thereafter, if requested by CDN.

- In a case where a parent is required by a court or administrative order to provide coverage for a child, the Plan shall not disenroll or eliminate coverage unless a) the employer has eliminated coverage for all employees, b) the plan is provided with satisfactory written evidence that either the court order or administrative order is no longer in effect, or c) the child is or will be enrolled in another or comparable plan that will take effect no later than the effective date of the child's disenrollment.

- Domestic partners are same-sex and opposite-sex couples who have registered with any state or local government domestic partnership registry; there are no requirements for proof of relationship or waiting periods that are not also applied to married couples; and COBRA-like continuation coverage is available to domestic partners and their children to the same degree and in the same manner as COBRA coverage is available to spouses and stepchildren

V. CHOICE OF PROVIDER AND PROVIDER COMPENSATION

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

You may select any CDN Provider for you and your family's dental care. All family members MUST use the same office and the plan subscriber must live or work within CDN's service area within California. A request to change dental office may be done by contacting CDN toll-free at 1-877-433-6825 or by requesting such in writing to CDN's office. Any such change will become effective on the first day of the month following CDN's approval if request is received by CDN by

the 20th of the month. CDN may require up to 30 days to process any such request. All Member fees and Copayments must be paid in full prior to such a transfer.

A copy of CDN's policy regarding second opinions is available upon request from the Member Services Department of CDN.

In consideration of the performance by the Provider of all services required to be provided pursuant to the Subscriber Agreement and Benefit Schedule for each Plan Member, the compensation to the Provider shall be:

- The copayments paid directly to the CDN Provider by the Member as set forth in the Benefit Schedule and this Evidence of Coverage and Disclosure form, and
- The Capitation paid to the Provider by CDN and/or
- Any direct reimbursement by CDN based on specific services provided as allowed by our Dental Services Agreement with the Provider.

CDN does not have, in any contract and/or agreement with a Provider or other licensed health care professional, any such compensation agreement term that includes a specific payment or compensation made directly, in any type or form, as an inducement to deny, reduce, limit or delay, any specific, medically necessary, or appropriate services.

VI. FACILITIES

CDN's participating dental offices are open during normal business hours and some offices are open limited Saturday hours. Please remember; if you cannot keep your scheduled appointment, you must notify your dental office at least 24 hours in advance or you may be responsible for a broken appointment fee (please refer to your Benefit Schedule).

VII. PREPAYMENT FEE

Subscribers and/or Groups agree that CDN shall provide services set forth in this brochure at the rates specified in the Agreement and the Benefit Schedule upon payment of the monthly or annual Prepayment Fee. The Prepayment Fee shall be sent to CDN. Subscriber should consult the contract holder or Agreement for specific information regarding any sums to be paid or withheld from the Subscriber's salary or to be paid by subscriber. For Groups, depending on the size of the Group, there may be a monthly billing charge.

VIII. LIABILITY OF MEMBER FOR PAYMENT

By statute, every contract between CDN and a Provider shall provide that in the event that CDN fails to pay the Provider, the Member shall not be liable to the Provider for any sums owed by CDN.

In the event that CDN does not pay non-contracting providers, the Member may be liable to the non-contracting provider for costs of services.

Members will be responsible for all supplementary charges, including copayments, deductibles and procedures not covered as Plan Benefits.

IMPORTANT: If you opt to receive dental services that are not covered services under this Plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the

dentist should provide the patient with a treatment plan that includes each anticipated service. If you would like more information about dental coverage options, you may call member services at 1-877-433-6825 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

IX. COORDINATION OF BENEFITS

In the event a Member is covered under another plan or policy which provides coverage, benefits or services (plan) that are covered benefits under this Plan, then the benefits of this Plan shall be coordinated with the other plan according to regulations on "Coordination of Benefits". These regulations determine which plan is primary and which is secondary under various circumstances. Generally, they result in a group plan being primary over an individual plan and that a plan covering the Member as a subscriber is primary over a plan covering the Member as a dependent. Typically, Coordination of Benefits will result in the following:

If the other coverage is a group indemnity plan:

If the group indemnity coverage is primary, the provider will usually bill the carrier for their Usual and Customary Fees, and the Member will be charged the copayment under the secondary plan less the amount received from the primary coverage.

If the group indemnity coverage is secondary, the provider will bill the carrier for the amount of copayments under the primary plan, and the Member will be responsible for the copayments under the primary plan less the amount paid by the secondary carrier.

If the other coverage is a prepaid plan:

If the provider participates in both plans, the Member should be charged the lower copayment(s) of the two plans.

If the provider does not participate in both plans, the plan that the provider participates in will be primary, and the other plan will typically deny coverage because the Member received services from a non-participating provider.

Members may not receive benefits for more than their out of pocket costs for the services provided as a result of Coordination of Benefits.

A copy of the Coordination of Benefits regulations may be obtained from CDN.

The Plan and/or its treating providers reserve the right to recover the cost or value, as set forth in Section 3040 of the Civil Code, of covered services provided to a Member that resulted from or were caused by third parties who are subsequently determined to be responsible for the injury to the Member.

X. EMERGENCY CARE

CDN covers emergency dental service 24 hours a day, seven days a week, to all Members. You need only contact your selected Provider office that will make arrangements for such emergency dental care. If your selected dental Provider office is unavailable during normal business hours, call CDN's office for instructions toll-free at 1-877-4-DENTAL. In the case of an after-hours emergency, you may obtain emergency service from any licensed dentist. You need only submit to CDN, at the address listed herein, the bill incurred as a result of the dental emergency, evidence of payment and a brief explanation of the unavailability of your Provider. A non-covered parent of a covered child may submit a claim for emergency care without the approval of the

covered parent, in such case the non-covered parent will be reimbursed. Upon verification of your Provider's unavailability, CDN will reimburse you up to $50.00 for the cost of emergency services, less any applicable copayment.

Enrollees are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response.

XI. REIMBURSEMENT PROVISION FOR OUT-OF-AREA CARE

Members and enrolled Dependents are covered for emergency dental treatment arising while temporarily more than 50 miles from their selected CDN office.

Member claims must be filed within 60 days and CDN will reimburse Members within 30 days for any emergency expenses in connection therewith up to $50.00 per person per year, upon presentation of a detailed statement from the treating dentist indicating all services provided. A non-covered parent of a covered child may submit a claim for an out-of-area emergency without the approval of the covered parent, in such case the non-covered parent will be reimbursed. Emergency dental service is recognized as dental treatment for the relief of pain, bleeding or any condition that may result in disability or death and covers only those dental services required for such conditions. Submit all claims for reimbursement to CDN at the address listed herein.

XII. SPECIALIST REFERRALS

Should a Member's CDN Provider determine that the services of a specialist are required for the Member's treatment, CDN will forward the Member, and/or the non-covered parent of a covered child, a letter of treatment authorization, including the name and address of the nearest CDN specialist. If an emergency referral is determined, the Member's Provider will contact CDN and prompt arrangements will be made for specialty treatment. Costs of services provided by a dental specialist may be the responsibility of the Member. All requests for specialty care must be previously approved. Both the general provider and the patient will be notified in writing of approval or denial.

A copy of the Plan's written policies for Utilization Review and Specialty Referral are available upon request.

If you request services from any specialist without prior written approval from CDN, you will be responsible for the specialist's fee for any services rendered.

XIII. CONTINUATION OF COVERAGE

ACUTE CONDITION OR SERIOUS CHRONIC CONDITION

At the request of the enrollee, the Plan will, under certain circumstances, arrange for continuation of covered services rendered by a terminated provider to an enrollee who is undergoing a course of treatment from a terminated provider for an acute condition or serious chronic condition. In the event the enrollee and the terminated provider qualify, the Plan will furnish the dental services on a timely and appropriate basis for up to 90-days or longer if necessary, for a safe transfer to another provider as determined by the Plan in consultation with the terminated provider, consistent with good professional practice.

The payment of copayments, deductibles, or other cost sharing components by the enrollee

during the period of continuation of care with a terminated provider shall be the same copayments, deductibles, or other cost sharing components that would be paid by the enrollee when receiving care from a provider currently contracting with or employed by the Plan. The Plan will not cover services or provide benefits that are not otherwise covered under the terms and condition of the Plan contract.

For the purpose of this section:

"Terminated Provider" means a provider whose contract to provide services to Plan enrollees is terminated or not renewed by the Plan or one of the Plan's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the Plan or contracting provider group.

"Acute Condition" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or medical problem that requires prompt medical attention and that has a limited duration.

"Serious Chronic Condition" means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

(a) Persists with full cure or worsens over an extended period of time.
(b) Requires ongoing treatment to maintain remission or prevent deterioration.

To request consideration of the continuance of services from a terminated provider because you have an acute or serious chronic condition, call or write the Plan.

XIV. EXCLUSIONS AND LIMITATIONS

The Plan's basic Limitations and Exclusions are applicable to all basic plan designs (Group and Individual Plans 100 to 695, and UABT plans). Some limitations and exclusions are waived for Members on Advantage Plans and Plans with the Cosmetic Benefits Rider. See Clinical Guidelines for specific policies.

EXCLUSIONS

- General anesthesia, analgesia (nitrous oxide), intravenous sedation, or the services of an anesthesiologist.
- Treatment of fractures or dislocations; congenital malformations; malignancies, cysts, or neoplasms; or Temporomandibular Joint Syndrome (TMJ).
- Extractions or x-rays for orthodontic purposes.
- Prescription Drugs and over the counter medicines.
- Any services involving implants or experimental procedures.
- Any procedures performed for cosmetic, elective, or aesthetic purposes.
- Any procedure to replace or stabilize tooth structure lost by attrition, abrasion, erosion, or bruxism (grinding).
- Any procedure not specifically listed as a covered Benefit.
- Covered services provided outside of the CDN general dentist's office that the Member selected, or was assigned to, unless expressly authorized by CDN.

- Services which, in the opinion of the attending CDN dentist, cannot be performed because of physical or behavioral limitations of the Member.
- Services for injuries or conditions, which were caused by acts of war or are covered under Worker's Compensation or Employer's Liability Laws.
- Services which, in the opinion of the attending CDN dentist are not necessary for the Member's dental health, or which have a poor prognosis.
- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
  Damage to teeth due to harmful habits including, but not limited to, mouth jewelry, tongue piercing, etc.

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 12 months for Members up through age 14.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal scaling and root planing is limited to one treatment per quadrant in any 12-month period.
- Except as noted in Clinical Guidelines, fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, the fixed bridge is considered optional treatment.
- Replacement of partial dentures is limited to once every five years, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Full upper and/or lower dentures are not to exceed one each in any five-year period.
- Replacement will be provided by CDN for an existing full or partial denture only if it is unserviceable and cannot be made serviceable by either reline or repair.
- Denture relines are limited to one per arch in any 12-month period.
- Sealants, when covered, are limited to permanent first and second molars for members up through 14 years of age.
- Replacement of a restoration is covered only when dentally necessary.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- Services of a specialist are covered Benefits only when specifically listed, and when covered.
- Pedodontic referrals are limited to those Benefit programs that have Specialist Coverage and are limited to Members up through age five, and at 50% of the pedodontist's fees to a maximum of $500 per Member per year.
- Optional Treatment – Except as noted in Clinical Guidelines, if (1) a less expensive alternative procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition, as determined by the Plan; and (2) the

alternate treatment will produce a professionally satisfactory result with a good prognosis; then the maximum eligible dental expense to be considered for payment will be the less expensive treatment.

- Crowns and bridge units are limited to five per arch per year.

ADDITIONAL EXCLUSIONS & LIMITATIONS FOR ORTHODONTICS

- Orthodontic treatment must be rendered by a participating CDN Orthodontist and the Member must remain eligible throughout the period of active orthodontic treatment.
- Members losing eligibility during treatment will be charged the treating Orthodontist's usual and customary fees for any unfinished treatment.
- Orthodontic Benefits are for 24 months of active treatment. Treatment in excess of 24 months (extended treatment) is available at the participating CDN Orthodontist's usual and customary fees. Members whose treatment is extended because of gross noncompliance, or who change Providers while in active treatment, will incur additional charges.
- Members who are 18 years of age or younger on the date the orthodontic bands are placed, are eligible for the transitional or adolescent co-payments. All other Members are considered adults and are subject to the adult dentition co-payment.
- Unless specifically listed in the Summary of Benefits, the following are not covered:
    - Benefits under this Evidence of Coverage and Disclosure Form:
        - Study Models and Initial Diagnostic Work-up
        - X-rays for Orthodontic Purposes
        - Tracings and Photographs
        - Extractions for Orthodontic purposes
        - Phase I Orthodontic Treatment
- The following are not included as an Orthodontic Benefit:
    - Replacement or repair of lost or broken appliances,
    - Re-treatment of orthodontic cases,
    - Treatments started or in progress prior to a Member's eligibility,
    - Changes in treatment necessitated by an accident,
    - Orthodontic treatment that involves:
        - Maxillofacial surgery, myofunctional therapy, cleft palate, micrognathia, and/or macroglossia,
        - Surgically exposing impacted teeth (i.e. Maxillary cuspids),
        - Hormonal imbalances or other factors causing growth and development abnormalities,
        - Treatment related to Temporomandibular Joint disturbances (TMJ),
        - "Invisible braces"--Lingually placed direct bonded appliances and arch wires, treatment with removable clear positioner systems, etc.
        - Cases involving surgical orthodontics,
        - Severe or mutilated malocclusions.
        - Changes in treatment necessitated by accident of any kind.

XV. TERMINATION OF BENEFITS

CDN, the Member, or the Group may cancel the contract upon which Coverage is based should any party breach the terms or conditions of the contract. Health plan termination shall be effective the last day of the month in which the termination of the contract occurs.

Should a Member's employment with a Group end, the Member's Coverage will cease according to the rules of the Group.

Should the contract be terminated because the Group hasn't remitted to CDN any fees owed, and then pays CDN by the date the next payment is due, the contract will be automatically reinstated as if never terminated.

The contract will be terminated for Group's failure to remit the monthly Prepayment Fees, or provide eligibility list as required, in which case the Group will be given 15 days written notice. The Group will have 15 days to remit the appropriate Prepayment Fees, or eligibility list when due, from receipt of notice, in which to remedy the default.

Both parties agree that CDN shall have the absolute right to terminate this contract should Group fail to remit the monthly Prepayment Fees or eligibility list, within the 15-day period after notice.

The contract will be terminated should a Group engage in fraudulent conduct with respect to the contract.

If you believe your Membership has been cancelled or not renewed because of health status or requirements for services, you may request a review by the California Department of Managed Health Care. A reinstatement pursuant to this section shall be retroactive to the time of cancellation or failure to renew and the Plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement.

XVI. RENEWAL, REINSTATEMENT AND CHANGES PROVISIONS

CDN contracts with Members and Groups to provide services for specific time periods as specified in the Agreement. Members are covered under CDN for that period. The CDN contract may be renewed.

Members have no individual rights to renewal for reinstatement of the Subscriber Agreement if it is terminated by CDN because the Group or individual Subscriber has failed to make monthly payments when due or has otherwise breached the Agreement.

CDN reserves the right to change or alter in any manner the Benefits stated in the Agreement. Effect of such changes of services shall take place at least 30 days from and after notice of such.

XVII. INDIVIDUAL CONTINUATION OF BENEFITS

Members who become ineligible for Group Coverage may apply through their employer to continue Coverage under COBRA, if applicable. **Please see the section in this Evidence of Coverage and Disclosure Form below, entitled Cobra Information.**

CDN reserves the right to offer conversion privileges to Members who become ineligible due to termination of the Group Agreement. If conversion is offered to a Member, application must be made within 30 days of notice of ineligibility to continue the offered Plan Coverage. The terms and conditions under the Agreement in which such Member will be re-enrolled shall be at the option of CDN.

XVIII. COBRA INFORMATION

Pursuant to Consolidated Omnibus Budget Reconciliation Act (COBRA) legislation, this information will serve to advise Members of certain rights which their family members may have to continuation of Coverage under CDN, which they have as an employee Benefit, in the event of a termination of eligibility due to one of the following:

- Death of a covered employee.
- Termination of a covered employee (other than for gross misconduct) or reduction in covered employee's hours of employment.
- Divorce or legal separation of a covered employee from the employee's spouse.
- Entitlement to Medicare Benefits by a covered employee.
- A Dependent child ceasing to be eligible for coverage as a Dependent child under the Plan.

For widows, divorced spouses, spouses, eligible employees, and Dependent children who become ineligible under CDN, continuation Coverage may be available for up to 36 months. Continuation Coverage for terminated or reduced hour employees, and their eligible Dependents, may also be available for up to 18 months.

A monthly premium must be paid by the Member to CDN through the Group for the continuation coverage. The premium will be determined at the time of eligibility and will be subject to change; however, the premium charged to the Member will not exceed 102% of the premium charged for active employees and/or Dependents in a comparable status. The continuation Coverage will be the same as the Coverage available for continuing employees, regardless of a Member's health at the time. Coverage under COBRA must begin on the date of the qualifying event.

Continuation coverage will **not** be available to Members after:

- Member fails to make timely premium payments, OR
- Member or Member's spouse or Dependent is covered under any other Group health plan as the result of employment, re-employment or re-marriage, OR
- Member or Member's spouse or Dependent becomes entitled to Medicare Benefits, OR
- The Group or former employer ceases to maintain the Plan for employees.

At the time of eligibility for continuation Coverage, an election form will be provided to the Member by the Group. The form must be completed and returned to the Group by the date noted. The Member and the Member's Dependents must notify the Group of a divorce, legal separation or loss of eligibility of a Dependent child upon the occurrence of such event.

Members should direct any questions about this Benefit to their Groups.

CDN also offers Members the option of obtaining Coverage under an individual Plan with Benefit Schedules that may differ from their Group Plan.

XIX. CAL-COBRA INFORMATION

Pursuant to California Continuation Benefits Replacement Act or "Cal-COBRA" legislation, this information will serve to advise Members of certain rights which their family members may have to continuation of Coverage under CDN, which they have as an employee Benefit of employers with 2 to 19 eligible employees who are not currently offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) legislation, in the event of a termination of eligibility due to one of the following qualifying events:

- Death of a covered employee

- Termination of employment (other than for gross misconduct) or reduction in covered employee's hours of employment.

- The divorce or legal separation of the covered employee from the covered employee's Spouse.

- The loss of dependent status by a Dependent enrolled in the group benefit plan.

- With respect to a covered Dependent only, the covered employee's entitlement to benefits under Medicare.

Continuation coverage will **not** be available to Members as follows:

- Individuals who are entitled to Medicare benefits or who become entitled to Medicare benefits.

- Individuals who have other dental (hospital, medical, or surgical) coverage or who are covered or become covered under another group benefit plan, including self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary.

- Individuals who are covered, become covered, or are eligible for federal COBRA coverage.

- Qualified beneficiaries who fail to meet the requirements regarding notification of a qualifying event or election of continuation coverage within the specified time limits.

- Member fails to make correct and timely premium payments or fails to satisfy other terms and conditions of the Plan contract.

For widows, divorced or legally separated spouses, spouses, eligible employees, and Dependent children who become ineligible under CDN, continuation Coverage may be available for up to 36 months. Continuation Coverage for terminated or reduced hour employees, and their eligible Dependents, may also be available for up to 18 months.

A monthly premium must be paid by the Member to CDN through the Group for the continuation coverage. The premium will be determined at the time of eligibility and will be subject to change; however, the premium charged to the Member will not exceed 110% of the premium charged for active employees and/or Dependents in a comparable status. The continuation Coverage will be the same as the Coverage available for continuing employees, regardless of a Member's health at the time.

Members should direct any questions about this Benefit to their Groups.

CDN also offers Members the option of obtaining Coverage under an individual Plan with Benefit Schedules that may differ from their Group Plan.

All Members who are eligible to be qualified beneficiaries are required, as a condition to receive benefits, to notify CDN in writing or the employer of the qualifying event within 60-days of the date of the qualifying event. Failure to make such notification with the 60-days will disqualify the qualified beneficiary from receiving coverage under Cal-COBRA. Additionally, the notification must request the continuation of benefits and must be delivered by first class-mail or other reliable means of delivery including personal delivery, express mail or private courier company to CDN or the employer within 60-day period following the later of (1) the date that the Member's coverage under the group benefit Plan terminates or (2) the date the Member was sent notice of the ability to continue coverage under the group benefit Plan.

A qualified beneficiary electing continuation shall pay CDN in accordance with the terms and conditions of the Plan contract, the required premium payment amount. The first payment required to establish premium payment must equal an amount sufficient to pay any required premiums and all premiums due and must be delivered by first-class mail, certified mail, or other reliable means of delivery including personal delivery, express mail or private courier company to CDN or the employer within 45-days of the date the qualified beneficiary provided written notice to CDN or the employer. Failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage.

If the Member's continuation coverage terminates under a prior group benefit plan, the Member may continue coverage for the balance of the period that would have remained covered under the prior group benefit plan, including the requirements for election and payment. Continuation coverage shall terminate if the Member fails to comply with the requirement pertaining to enrollment in, and payment to, the new group benefit plan within 30-days of receiving notice of the termination of the prior group benefit plan.

XX. COMPLAINTS, DISPUTES AND GRIEVANCES

Any complaint you may have should initially be brought to the attention of your Provider. If it is not resolved to your satisfaction, you are encouraged to contact CDN. Any information, inquiries, complaints or disputes regarding any problems that are encountered while obtaining services should be made to CDN. Complaint forms as well as a copy of CDN's Grievance Procedures are available upon request. Member complaints or grievances can be made in person, at any Provider's office or by obtaining a Grievance Form from CDN by writing, faxing or calling CDN as follows, or by visiting the website at *www.caldental.net*:

California Dental Network, Inc.
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653
Phone (949) 830-1600: Toll-Free (877) 4-DENTAL
Fax (949) 830-1655

Completed Grievance Forms must be mailed to CDN at the address listed above.

Members, or their representatives, with limited English proficiency or with visual or other communicative impairment can contact the Plan for assistance at the numbers listed above.

CDN agrees to duly investigate and endeavor to resolve any and all complaints received. Member complaints will be acknowledged in writing within five calendar days of receipt by the Plan. Members will receive a written response within 30 days as to the disposition of the complaint, or measures taken to correct any problems. Such written response to a grievance will provide subscribers and enrollees with a clear and concise explanation of the reasons for the Plan's response. For grievances involving the delay, denial, or modification of health care

services, the Plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If the Plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the Member, the decision shall clearly specify the provisions in the contract that exclude that coverage. Members who are not satisfied with the Plan's response to the Grievance have the right to file a complaint with the California Department of Managed Healthcare.

If the complaint or grievance requires an immediate review for an urgent or emergency quality of care issue, as defined in the Emergency Referral section of the Quality Assurance Program, including severe pain, as determined by the Plan's Dental Director, the time period for Plan action as set forth above shall not apply. In such cases, the complaint or grievance will be handled by the Plan within three business days, and the Plan Member will be notified of the result immediately thereafter. Members and the Department of Managed Health Care will be provided with the status as quickly as possible and, in the case of written statements, within three days of receipt of the grievance.

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 **1-949-830-1600 or toll-free 1-877-4-DENTAL** and use your Health Plan's grievance process before contacting the Department. For the hearing and speech impaired, dial **711** to call with the **Telecommunications Relay Service**. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

The department may require enrollees and subscribers to participate in a plan's grievance process for up to 30 days before pursuing a grievance through the department. However, the department may not impose this waiting period for expedited review cases covered by subdivision (b) of Section 1368.01 of the California Health & Safety Code or in any other case where the department determines that an earlier review is warranted.

Health Plan Linguistic and Cultural Policy Regarding Grievances

The Plan's grievance system ensures that all Members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. When requested by a Member and/or his or her representative, the Plan will assist Members with limited English proficiency to obtain translation or interpretation of the Plan's grievance procedures, forms, and responses to grievances. The Plan will assist Members with visual or other communicative impairments in locating telephone

relay systems and other devices and/or services that aid disabled individuals to communicate, so that the Member may participate in the grievance system.

Members who file a grievance against the Plan will not be discriminated or retaliated against in any way.

XXI. BINDING ARBITRATION

Any complaint, dispute or grievance arising between a Group and CDN, or between a Member and CDN, not resolved by CDN's grievance system and involving the Agreement or any of its terms and conditions, its breach or non-performance, or involving any claim of dental malpractice, shall be settled by arbitration pursuant to the rules and regulations then in force and effect of the American Arbitration Association.

The arbitration shall take place in Orange County, California and judgment upon any award rendered by the arbitrator may be duly entered in any court in the State of California having jurisdiction thereof.

The prevailing party shall be entitled to court costs and reasonable attorney's fees. CDN will assume all or part of the Member's share of the fees and expenses of the neutral arbitrator

XXII. DISCLOSURE AND CONFIDENTIALITY OF INFORMATION

All personal and medical records (including any personal or privileged information, medical records, patient charts, etc.) shall remain confidential. Such confidential information may be reviewed by CDN as required by its staff and Quality Assurance Committee.

Such information may also be made available to the Department of Managed Health Care, the Dental Board and CDN's legal representatives or other agencies as required by law.

A Plan Member or the non-covered parent of a covered child may request access to or a copy of personal information and medical records. Written consent for release of patient information and records is required to be signed by the patient, along with the appropriate fee, as allowed by law, before any records will be released. CDN will respond to such a request within 30 days after receipt of the appropriate executed forms and fees.

California Dental Network's confidentiality policy is available for review to all Plan Members upon request.

A Plan Member may request to have an addendum of 250 or fewer words added to his or her medical records, in compliance with state law. This request should be made directly to the provider who has custody of the records. Should the provider deny Member the request to add an addendum, the Member should contact CDN for assistance.

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

XXIII. ADDITIONAL INFORMATION

If the Provider fails to comply with the terms and conditions of this Evidence of Coverage and Disclosure Form, the Member should advise CDN of the Provider's breach of the Agreement.

CDN has a Public Policy Committee that reviews and approves all actions of the Quality Assurance Committee. This Committee reports to the Board of Directors. The Public Policy committee is composed of at least 51% Members and health care Providers. Members who would like to participate on this Committee should submit their request to CDN's President.

XXIV. ORGAN AND TISSUE DONATION

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

XXV. INDEPENDENT MEDICAL REVIEW

External independent review is available to Members for review of denials of experimental therapies where such therapies might be indicated for treatment of a life threatening condition or seriously debilitating illness or for denials based on service not being medically necessary by contacting Member Services within five business days of the denial. The request for an independent medical review will be reviewed by the Dental Director or, if necessary, referred to the Quality Assurance Committee. Timeframes for considering independent medical review requests will be the same as for grievance processing. Members have the right to file information in support of the request for independent medical review.