Individual Subscriber Agreement

Combined Evidence of Coverage

And

Disclosure Form

This Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form contains the exact terms and conditions of coverage.

This Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage.

With respect to individual plan Subscriber Agreements, small group plan Subscriber Agreements, and any other group plan Subscriber Agreements for which health care health care services are not negotiated, the applicant has a right to view this Individual Subscriber Agreement, Combined 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 Individual Subscriber Agreement, Combined 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.

The dental health plan benefits and coverage matrix is located at the end of this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form.

Members will have 30 days from receipt of the Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form to cancel their enrollment and receive a full refund of their premiums if they have not utilized the plan.

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 this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form by which its terms limits the eligibility of Subscribers and enrollees. The completed Enrollment Application and schedule of Principal Benefits and Coverage under which the Member is enrolled along with this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form, will constitute the entire Agreement.

Benefits or Coverage mean the health care services available under this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form and the Benefit Schedule under which a Member is enrolled.

Benefit Schedule means the schedule of Principal Benefits & Coverage which list the Benefits specifically covered under each plan and denotes 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.

Copayment means an additional fee charged to a Subscriber or enrollee which is approved by the Commissioner, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

Dependents shall mean the lawful spouse and dependent 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.

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

Limitation means any provision other than an Exclusion which restricts Coverage under this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form.

Member shall mean the Subscriber or any eligible Dependent who is enrolled and whose premiums are paid under this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form.

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 Subscriber and his or her enrolled eligible Dependents' coverage under the Subscriber Agreement.

Provider means a licensed California dentist who has contracted with 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 this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form and who is responsible for the premium payment to CDN.

II. HOW TO USE CDN

In addition to this Individual Subscriber Agreement, Combined 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.

A complete list of covered services is enclosed in the Benefit Schedule along with the required copayments. 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 or specialist are not covered. Under certain emergency situations as explained under the section titled Emergency Care, services by a non-contracted general dentist may be covered.

III. ELIGIBILITY

Subscribers and eligible Dependents must either live or work within the CDN approved service are in order to be eligible for Benefits hereunder. When payment and application are received and approved by the 20th of the month, eligibility will commence on the first of the following month.

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 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.

California has legalized registered domestic partnerships for same-sex and opposite-sex couples. In order for two individuals to be considered domestic partners in California, they must be in an intimate, committed relationship and file a Declaration of Domestic Partnership with the California Secretary of State. When the declaration is filed, the following requirements must also be fulfilled:

- Each individual is at least 18 years of age, unless consent is given from the minor's parent or guardian;
- Neither individual is related by blood in any way that would prevent marriage in the state;
- Neither individual is married, or in another domestic partnership with another individual;
- Both individuals are of the same sex or, if the individuals are of the opposite-sex, at least one person is over 62 years of age; and
- Both individuals are capable of consenting to a domestic partnership.

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.

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 services made available and/or rendered to Members pursuant to this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form and the schedule of Principal Benefits and Coverage, the compensation to the Provider shall be:

- The copayments paid directly to the CDN Provider by the Member as set forth in this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure form, and/or
- 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 agree that CDN shall provide services set forth in this Individual Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form at the rates specified in the Enrollment Application and the Benefit Schedule upon payment of the monthly or annual Prepayment Fee. The Prepayment Fee shall be sent to CDN.

VIII. LIABILITY OF MEMBER FOR PAYMENT

By statute, every contract between CDN and a participating Provider shall provide that in the event that CDN fails to pay the participating 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 rendered.

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.

This individual plan is secondary to all other group coverage the member may have.

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, and your selected dental provider is unavailable, 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 their 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

Not all general dentists are capable of performing each of the services listed herein and, based upon the Member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such cases, the general dentist will refer the member to a dental specialist. **The costs of services provided by a dental specialist are NOT a covered benefit under this plan,** however, 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. 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 contracted 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 contracted 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.

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.

XIV. EXCLUSIONS

- Specialist – All dental services must be provided by your participating general dentist. Services of a specialist are excluded under this individual benefit program.

- 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 grinding.
- Any procedure not specifically listed as a covered Benefit.
- Services provided outside the CDN general dentist's office that the Member selected, or was assigned, to receive covered services, unless expressly authorized by CDN.
- Services, which in the opinion of the attending CDN dentist, cannot be preformed 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 mouth jewelry, for example tongue piercing.

XV. LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 12 months for Members up to 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 treatments (sub-gingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- 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 to the 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 referral and services are covered at 50% of the pedodontist's fees.

- Optional Treatment – 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; then the maximum eligible dental expense to be considered for payment will be the less expensive treatment.

- Crowns are limited to five per arch per year.

XVI. ADDITIONAL EXCLUSIONS AND 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. Member's 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 non-compliance 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 Children copayments. All other Members are considered adults and are subject to the adult 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, 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),
- Lingually placed direct bonded appliances and arch wires - "invisible braces",
- Cases involving surgical orthodontics,
- Sever or mutilated malocclusions.

XVII. TERMINATION OF BENEFITS

Either CDN or the member may cancel this Subscriber Agreement if any party breaches the terms or conditions of this Subscriber Agreement. Health plan termination shall be effective the last day of the month in which the termination of this Subscriber Agreement occurs.

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

This Subscriber Agreement will be terminated for Subscriber's failure to remit the Prepayment Fees, or provide eligibility list as required, in which case the Subscriber will be given 15 days written notice. The Subscriber will have 15 days to remit the appropriate Prepayment Fees, 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 Subscriber Agreement should Subscriber fail to remit the Prepayment Fees, within the 15-day period after notice. In the event of cancellation by either the Plan (except in the case of fraud or deception in the use of services or facilities of the Plan or knowingly permitting such fraud or deception by another) or the other party, the Plan shall within 30 days return to the other part the pro rate portion of the money paid to Plan which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due the Plan.

This Subscriber Agreement will be terminated should a Subscriber engage in fraudulent conduct with respect to this Individual Subscriber Agreement.

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 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.

XVIII. RENEWAL, REINSTATEMENT AND CHANGES PROVISIONS

CDN Subscriber Agreements with Members to provide services for specific time periods as specified hereunder. Members are covered under CDN for that period. The CDN Subscriber Agreement may be renewed.

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

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

XIX. 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 shown 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 statement, 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 an 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.

XX. BINDING ARBITRATION

Any complaint, dispute or grievance arising 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

XXI. 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 it's 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.

XXII. 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.

XXIII. 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.

XXIV. GENERAL PROVISIONS

- CDN is subject to the requirements of the Act and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provisions required to be in this Agreement by

either of the above shall bind CDN whether or not provided in this Agreement. In the event that the Act or Regulations thereunder set forth any requirement that is not included herein or is contrary to this Agreement, it shall supersede the applicable provisions of this Agreement and shall be binding unto the parties hereto.

- Nothing contained herein shall preclude CDN from changing the location of any of its dental offices, as long as it retains a sufficient Provider network to provide dental services to Group.

- In the event any of CDN's Providers should terminate their relationship with CDN, breach their Subscriber Agreement with CDN, or be unable to render dental services hereunder, and Subscriber and or its Subscribers would be adversely or materially affected, CDN will give Subscriber written notice thereof.

- Upon termination of a Provider Contract, CDN shall be liable for covered services rendered by such Provider (other than for Copayments as defined in subdivision (g) of Section 1345 of the Act) to Members who retain eligibility under this Agreement or by operation of law under the care of such Provider at the time of such termination until the services being rendered to the Members by such Provider are completed, unless CDN makes reasonable and medically appropriate provisions for the assumption of such services by another Provider.

- If any provision of this Agreement is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Agreement, and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevent the accomplishment of the objectives and purposes of this Agreement.

- This Agreement is non-assignable by either party without the prior written consent of the other party. CDN may, in its sole discretion, delegate administrative functions to other entities.

- This Agreement constitutes the entire Agreement of the parties. This Agreement may only be modified in writing and executed by the parties.

- Pursuant to Section 1365(b) of the Act, any Subscriber who alleges his enrollment has been cancelled or not renewed because of his health status or requirement for services may request review by the California Department of Managed Health Care. A reinstatement pursuant to this subdivision 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.

- It is expressly understood that the relationship between Members and Providers shall be subject to the rules, limitations and privileges incident to the doctor-patient relationship. CDN shall be solely responsible to the Member for arranging dental advice and treatment, including the right to object to treating any Member who continually fails to follow a prescribed course of treatment, who uses the relationship for illegal purposes, or who attempts to make onerous the doctor-patient relationship.

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.