Western Dental Benefits Division

Evidence of Coverage and Summary Plan Description

CCPOA
Benefit Trust Fund
Pre-Paid Dental Program
& Provider Network

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WELCOME TO WESTERN DENTAL.

This Evidence of Coverage Booklet, which includes the Combined Evidence of Coverage and Disclosure Form and the accompanying Schedule of Benefits ("Evidence of Coverage") describes the dental program (the "Program") being offered by Western Dental Services, Inc. ("Western Dental"), and discloses the terms and conditions of coverage. All applicants have the right to review this Evidence of Coverage Booklet prior to enrollment.

The Evidence of Coverage Booklet explains your rights and responsibilities as a Western Dental Participant. It also explains Western Dental's responsibilities to you. The Evidence of Coverage Booklet contains impor tant information, and should be read completely and carefully. Individuals with special health needs should read carefully those sections that apply to them. Please keep the Evidence of Coverage Booklet in a safe place, available for quick reference. If you would like to receive additional information about the benefits of enrollment in Western Dental, please call us at: 1-800-992-3366.

This Evidence of Coverage Booklet does not take effect until the Group Subscriber Agreement ("Agreement") between your employer, association, or other entity through which you obtain coverage under the Program ("Group") and Western Dental is approved and executed by Western Dental and the Group.

This Program shall be construed under the laws of the State of California, unless preempted by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"); and any action relating to this Program shall be instituted and prosecuted in the county in the Western Dental Service Area in which you reside at the time the Group Subscriber Agreement ("Agreement") was executed, or such other location as may be required by ERISA, or in such other location as the parties may mutually agree in writing.

Please Note: Except for Emergency Care and services prior authorized by Western Dental to be provided by non-Participating Providers, the Covered Services under this Program are available only when provided by Participating Providers in accordance with all the terms and conditions of coverage described in this Evidence of Coverage Booklet and the Agreement.

It is your responsibility to determine whether the dentist or specialist dentist you use is a Participating Provider. It is also your responsibility to determine whether or not a referral made by your dentist or Participating Provider is to a Participating Provider. Even though your dentist may be a Participating Provider, do not assume that his or her referral

to another dentist/specialist or facility is a determination that such dentist/specialist or facility is also a Participating Provider. If you are in doubt about the status of any dentist or facility call Western Dental's Customer Service Department for verification.

Western Dental welcomes your participation on its Public Policy Commit tee, which meets quar terly at Western Dental's corporate offices in Orange, California. In order to be considered for membership, please write or call Western Dental's Customer Service Department.

ORGAN AND TISSUE DONATION

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

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

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 to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Western Dental's Customer Service Department, toll-free, at 1-800-992-3366 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Multilingual Services

If you or your representative prefer to speak in any language other than English, please call Western Dental, toll-free, at 1-800-992-3366 to speak with a Western Dental Customer Service Representative. Our Customer Service staff can help you find a Participating Provider who speaks your language or who has a regular interpreter available. You do not have to use family members or friends as interpreters. If you cannot locate a Participating Provider who meets your language needs, you can request to have an interpreter available for discussions of medical information at no charge. To request translated materials, please call Western Dental, toll-free, at 1-800-992-3366.

I. TYPE OF PROGRAM

The Western Dental Services, Inc. ("Program") is a prepaid dental program sponsored by the CCPOA Benefit Trust Fund ("Trust"), which uses a closed panel of providers. The Program is a component of the CCPOA Benefit Trust Fund Health and Welfare Plan.

IMPORTANT NOTE TO NEW HIRES:

Mandatory Enrollment in the Prepaid Dental Program

If you are a new hire in Bargaining Unit 6, this is the only dental program available to you and your Eligible Dependents for the first twelve (12) months of your eligibility for coverage. At the end of this twelve (12) month period, you have a period of sixty (60) days during which you may switch your coverage to the Primary Dental Program offered through the Trust. If you do not take any action within the sixty (60) day period, you may not change dental programs until the nex t annual open enrollment period which is generally held in the Fall.

Identification Card

Western Dental Services, Inc. ("Western Dental") issues you and your Eligible Dependents who you enroll in the Program an identification card to be presented at the time that services are to be rendered by the Professional Provider.

II. PARTICIPATION

Eligibility

If you are a full-time, permanent employee or a Permanent Intermittent Employee of the State of California Bargaining Unit 6, you and your Eligible Dependents are eligible to enroll in the Program on the first day you are actively at work. You will be enrolled in the Program and your coverage will begin on your Effective Date as described below. To enroll yourself and your Eligible Dependents, you must submit a completed enrollment application to your Personnel Office. By enrolling, you also agree to make any required contributions towards such coverage via payroll deduction.

If you are an employee of CCPOA or the Trust, you may enroll yourself and your Eligible Dependents by submitting a completed enrollment application to the Human Relations Department. You will be enrolled in the Program and your coverage will begin on your Effective Date as described below.

If you are a CCPOA member who was enrolled for benefits immediately preceding a suspension, termination or medical demotion while in Bargaining Unit 6, you may continue your enrollment in the Program by demonstrating to the Trust that you are actively challenging the employment action, and by self-paying the required contribution at least fifteen (15) days prior to the date your eligibility would otherwise cease.

Coverage under such circumstances will terminate when the suspension, termination or demotion ceases to be actively challenged, or thirty-six (36) months after such coverage commenced, whichever is earlier, or on the last day of the month for which contributions were received, if earlier.

Your Eligible Dependents include your lawful spouse or domestic partner (as defined in Section IV below), and children from birth to age twenty-six (26). Children include stepchildren and adopted children and children for whom you are the legal guardian, provided such children are dependent upon you for support and maintenance. Children also include your domestic partner's children, provided such children are dependent upon you or your domestic partner for support and maintenance. Your Eligible Dependents also include any child age twenty-six (26) or over, who is incapable of self-support because of physical or mental disability which existed continuously prior to age twenty-six (26). You must indicate on your application for enrollment that you wish to enroll your Dependents and pay the additional premium, if any, for them.

You may be required to provide proof of relationship, financial support or physical or mental disability for Dependent coverage.

Important Information:

State employees who are married or in a domestic partnership may not "duplicate" Dependent coverage; all Dependent children must be enrolled by only one State employee. If your spouse, domestic partner and/or your Dependent child enrolls as a State employee, their coverage as a Dependent must be terminated on the effective date of their enrollment as an employee. There is no dual coverage allowed. Employees and their spouses, domestic partners and/or Dependent children may not have dual coverage under any dental plan offered by the State of California.

The Program must recognize any Qualified Medical Child Support Order (QMCSO), as defined in the federal Omnibus Budget Reconciliation Act of 1993, and enroll as directed by such Order any child of a Program Participant specified therein. A Qualified Medical Child Support Order is any judgment, decree or order (including approval of domestic relations settlement agreement) issued by a court which:

1. Provides the child of a Program Participant with child support or directs the Participant to provide the child with coverage under a health benefits plan, or

2. Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act which provides in part that if the employee parent does not enroll the child, then the non-employee parent or State agency may enroll the child.

To be Qualified, a Medical Child Support Order must clearly specify:

1. The name and last known mailing address of the Participant and the name and mailing address of each child covered by the order,

2. A reasonable description of the type of coverage to be provided by the Program to each such child,

3. The period of coverage to which the order applies, and

4. The name of each Program to which the order applies.

A Medical Child Support Order will not qualify if it would require the Program to provide any type or form of benefit or any option not otherwise provided under this Program, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of benefits by the Program under a Qualified Medical Child Support Order to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian.

No eligible Par ticipant's child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a Dependent on the parent's Federal income tax return or does not reside with the parent.

You may obtain a free copy of the procedures for submitting a Qualified Medical Child Suppor t Order by contacting Western Dental. A Qualified Medical Child Support Order includes a properly completed National Medical Support Notice. Requests for coverage under a Qualified Medical Child Support Order should be mailed to Western Dental at the address provided in Section XI below.

Effective Date of Coverage

If you file an enrollment application within sixty (60) days after becoming eligible, payroll deductions will commence the following month. You and your Eligible Dependents will become covered for benefits under the Program on the first day of the calendar month immediately following the date payroll deduction commences. That is your Effective Date of coverage. For example, if you are hired on first day of the month and eligible to participate on the basis of your work status, you must complete your enrollment application by the fifteenth day of the month to be eligible on the first day of the next month. Your Effective Date under the Program will be the first day of the month following a successful payroll deduction. You must be actively at work in order for coverage to start; otherwise, coverage will be delayed until you return to active work status.

Deferred Effective Date of Coverage

If you are already enrolled in the Program and need to add new Dependents, you may do so by completing an enrollment application with the personnel office at your correctional facility or institution. A new spouse must be enrolled within sixty (60) days of the date of marriage. A new domestic partner, or such domestic partner's children, must be enrolled within sixty (60) days of meeting the requirements of Section IV below.

A newly born or adopted child must be enrolled within sixty (60) days of the date of birth or placement with you.

When properly enrolled, coverage for your new spouse will commence on the first day of the month following the date of marriage, coverage for a domestic partner, or such domestic partner's children, will commence on the first day of the month following the date the requirements of Section IV below are met and coverage for your newly acquired Dependent child, other than a newborn, will commence on the first day of the month after acquiring the child. A newborn child will be covered from the date of birth provided that an enrollment application is filed within sixty (60) days from the date of birth.

Late Enrollment

If you do not enroll yourself or your Dependents within the time frames required under the Program, you and your Dependents may file an application to enroll for dental coverage at the next annual open enrollment period held each Fall. Coverage will become effective on the following January 1 provided that the premium deductions required are made and that you are actively at work (or upon return to active work, if still eligible).

Annual Options to Change Programs

Once each year, you are provided the opportunity to change dental programs. As an alternative to the Program, you may elect coverage under the Trust's Primary Dental Program.

The Effective Date of coverage for any changes made during the annual open enrollment in the Fall will be January 1 of the following year. If enrollment is not completed during the annual open enrollment period for a January 1 Effective Date, no change will be allowed until the next annual open enrollment period.

Termination of Benefits

Eligibility for benefits under this Program will cease under each of the following circumstances:

1. The first day of the month following the date that you retire;

2. The first day of the month for which you stop self payment contributions to the Program;

3. The first day of the month you are no longer eligible under the terms of the Program;

4. The date the Trust no longer provides coverage for a class of employees to which you belong;

5. When the Program terminates.

Eligibility for benefits for your Dependents will cease at the same time your eligibility terminates, except Dependent coverage will cease earlier under any of the following circumstances:

1. The date the Dependent no longer qualifies as an Eligible Dependent under the Program;

2. The first day of the month for which you discontinue self payment contributions to the Program for Dependent coverage;

3. The date that Dependent coverage ceases to be available under the Program.

If you believe your enrollment has been cancelled or not renewed because of your health status or requirements for services, you may request review by the Director of the Department of Managed Health Care.

Western Dental may terminate a Participant's enrollment in this Program under the following circumstances:

1. If Participant knowingly provides false information on his or her enrollment form, or fraudulently uses services or facilities of Western Dental or providers, or knowingly allows another person to do so. Termination is effective immediately on the date Western Dental mails notice of termination.

2. If Participant threatens Western Dental employees, providers, participants or other patients, or engages in repeated behavior that substantially impairs Western Dental's ability to provide services to the Participant or substantially impairs the ability of Western Dental or a provider to provide services to other par ticipants or patients. Termination is effective 15 days after notice is sent to Participant.

If coverage is terminated for any of the above reasons, Par ticipant for feits all rights to COBR A Continuation Coverage (unless the termination coincides with the occurrence of a COBRA qualifying event like a termination of employment) or to enroll in the Western Dental's Individual Conversion or other benefit plans in the future. Western Dental does not provide for Par ticipant reinstatement following termination of individual membership.

Note: If the Agreement with your Group is terminated by Western Dental, reinstatement of the Group's Agreement with Western Dental is subject to all terms and conditions of that Agreement.

RENEWAL PROVISIONS

Western Dental has contracted to provide Covered Services for a period as specified in the Agreement. Thereafter, the Agreement may be renewed, with or without amendments, as specified in the Agreement. The Group may terminate the Agreement by giving the other party sixty (60) days written notice prior to the termination date of the Agreement. Failure to give such notice shall automatically renew the Agreement for a subsequent renewal term as specified in the Agreement. During the term of the contract, Western Dental may not increase the Prepayment Fee, the Co-payment amounts paid by the Participants, or decrease the Covered Services in any manner during a contract term without a prior written agreement between Group and Western Dental.

III. COVERAGE CONTINUATION COBRA SELF PAYMENTS AND FMLA LEAVE OF ABSENCE

If you, your spouse or your Eligible Dependent children would otherwise cease to be eligible for dental benefits, self-payments may be made to the Trust through the Trust Office, under cer tain circumstances, described below. Enrollment applications for continued coverage are available and should be initiated through your Personnel Office.

In accordance with the Public Health Services Act, you, your spouse or your Eligible Dependent children can individually elect to continue coverage under "COBRA," (a federal law) for a limited time by making monthly payments to the Trust. Such COBRA coverage is available for a limited period of time following election. Pursuant to CCPOA Benefit Trust policy, the Program will also provide an ex tension of coverage for up to 36 months to your domestic partner and your domestic partner's Dependent children, as defined in Section IV below, who are covered by the Program on the day before the Qualifying Event, as described below. The extension of coverage provided pursuant to this policy will generally mirror the coverage provided pursuant to the COBRA regulations.

If one of the following events (known as a Qualifying Event) occurs, you, your spouse and your Eligible Dependent children have the right to continue coverage that was in effect at the time of the Qualifying Event. The following are Qualifying Events:

1. Reduction in work hours below the level of thirty (30) hours per week for full-time employees and for Permanent Intermittent Employees, the loss of sufficient hours/work schedule to maintain PIE status;

2. Termination of employment through resignation, layoff, discharge (other than for gross misconduct), strike, lockout, or retirement;

3. For you r spouse or Dependent child, the event of your divorce or legal separation (if you stop paying premiums for your spouse in anticipation of a divorce your spouse will be treated as losing coverage at the time of the subsequent divorce or legal separation)

4. For your spouse or Dependent child, the event of your death;

5. The loss of status as a Dependent child.

If less than the minimum work hours were reported for a month on your behalf (Item 1 above) or your employment terminates (Item 2 above), you, your spouse and your Eligible Dependent children are entitled to eighteen (18) months of COBRA coverage under the Program calculated from the date of the Qualifying Event. Each of the other above listed items (Items 3 through 5) entitles your spouse and Eligible Dependent children to thirty-six (36) months of coverage from the date of the Qualifying Event. The eighteen (18) month period may be

extended to thirty-six (36) months if a second Event (divorce, legal separation, death or Medicare entitlement, but not termination of employment) occurs during the eighteen (18) month period.

If you are entitled to Medicare and have a Qualifying Event because insufficient hours are reported for the month or your employment is terminated, your spouse and Eligible Dependent children will be allowed to continue their coverage until the later of:

I. Eighteen (18) months (or twenty-nine (29) months, if there is a disability extension as described below) from the date you did not work the required minimum work hours or your employment terminated; or

2. Thirty-six (36) months from the date you became entitled to Medicare. For example, if you turn sixty-five (65) and become entitled to Medicare and twelve (12) months later lose coverage under the Program due to retirement, your spouse and Eligible Dependent children will be entitled to twenty-four (24) months of COBRA coverage.

3. "Entitled to Medicare" means enrollment in Medicare Part A or B, whichever is earlier.

Self-payment for COBRA Coverage

The payment for COBRA coverage is borne entirely by you, your spouse, and your Eligible Dependent children. The Trust makes no contributions on your behalf. If you, your spouse or your Eligible Dependent children elect to continue coverage, you will be obligated to pay the full premium for such coverage plus a two percent (2%) administrative fee.

How to Obtain COBRA Coverage

Under COBRA, you, your spouse and your Eligible Dependent children have the responsibility to inform the Trust Office within sixty (60) days of one of these events:

- a divorce or legal separation; or
- a child losing Dependent status (Dependent status is defined as under age twenty-six (26), or incapable of self-support because of either physical or mental disability regardless of age) under the Program.

You will be notified of your rights to choose COBRA coverage within fourteen (14) days of the date the Trust Office receives notice of your Qualif ying Event. COBRA rights will be forfeited if the Trust Office is not notified of the Qualifying Event within the sixty (60) day time period.

The State of California Department of Personnel Administration has the responsibility to notify the Trust Office within thirty (30) days of the date coverage would otherwise be lost for one of the following reasons:

- your death; or

- termination of employment or you worked less than the minimum required work hours.

However, you, your spouse or your Eligible Dependent children should advise the Trust Office of these events as well. The Trust Office has fourteen (14) days following receipt of notice of such an event within which to notify you of your rights to continue coverage. Such notice will be sent to the address of record maintained by the Trust Office. It is your responsibility to keep the Trust Office informed of your current mailing address.

The Trust Office will send you a notice whenever the State of California Depar tment of Personnel Administration reports less than the minimum required work hours or your employment is terminated. You must sign and return the form to the Trust Office electing coverage within sixty (60) days of the date of the notice or you will not be eligible for COBRA continuation coverage. You do not have to show that you are insurable to choose COBRA coverage. COBRA rights will be forfeited if you, your spouse or your Eligible Dependent children do not file the COBRA election forms within this sixty (60) day period.

If you do not choose COBRA coverage, your coverage will end. However, your spouse and your Eligible Dependent children may elect COBRA coverage, independent of your decision, but they must also make their election within sixty (60) days of receiving the COBRA election forms.

Your initial COBRA coverage will be identical to coverage provided to similarly situated par ticipants under the Program. It may be modified if coverage changes for other Participants or family members. All spouses and Eligible Dependent children covered at the time of a Qualifying Event are eligible to continue coverage hereunder. In addition, if you elect COBRA coverage, you may add a spouse and Eligible Dependent children at an annual open enrollment period, but these Dependents will not be given the same rights as Dependents covered at the time of the initial Qualifying Event. You may add a Dependent child born to you or placed for adoption with you while you have COBRA coverage by notifying the Trust Office within sixty (60) days of the birth or placement. A newly-born Dependent child or adopted child added while you are on COBRA coverage will be given the same rights as any other Dependent who was covered at the time of the initial Qualifying Event.

Extended COBRA Coverage Due to Disability

If you, your spouse or your Eligible Dependent children are determined by Social Security to have been totally disabled at the time of your termination or reduction of hours or during the first sixty (60) days of COBRA coverage, COBRA coverage for you, your spouse and your Eligible Dependent children may be extended for eleven (11) months beyond the original eighteen (18) months, for a total of twenty-nine (29) months. To qualify for these additional eleven (11) months, such an individual must report the Social Security determination to the Trust Office before the original eighteen (18) month period

expires and within sixty (60) days after the date of the Social Security determination. Further, the Trust Office must be notified within thirty (30) days of the final determination that the qualified beneficiary is no longer totally disabled. Please note the premium for the additional eleven (11) months will be approximately fifty percent (50%) higher than the COBRA premium for the first eighteen (18) months if the COBRA coverage includes the disabled individual and the COBRA coverage would not be available in the absence of a disability.

Termination of COBRA Coverage

COBRA coverage will terminate earlier than the eighteen (18), twenty-nine (29) or thirty-six (36) month coverage periods upon the earliest to occur of any one of the events listed below:

1. The first day of a coverage month in which you, your spouse or domestic partner or your Eligible Dependent children fail to remit the required premium payments in full and on time (within forty-five (45) days following the submission of the initial COBRA election form and which payment must include the cost of coverage retroactive to the first day your coverage would have otherwise terminated, or within thirty (30) days following the due date established by the Trust Office for subsequent periodic COBRA payments); or

2. You, your spouse or domestic partner or your Eligible Dependent children have continued coverage for additional months due to a disability and there has been a final determination by Social Security that you, your spouse or your Eligible Dependent children are no longer disabled. Coverage will terminate thirty (30) days following the date the Social Security determination is made; or

3. The date the Program terminates; or

4. The first day of the month following the date you, your spouse or your Eligible Dependent children become covered under another plan which does not contain a limitation or exclusion for any pre-existing condition that is applicable to you, your spouse or your Eligible Dependent children under HIPA A or other applicable law; or

5. The date the person receiving COBRA coverage enrolls in Medicare Par t A or B, if the person becomes entitled to Medicare after he or she elected COBRA coverage.

If your marital status has changed, or if you acquire new Dependent children while on COBRA coverage or you or your spouse have moved, please contact the Trust Office. Please let the Trust Office know of any Qualifying Event even if the State of California Department of Personnel Administration is otherwise required to give notice to the Trust Office.

Following COBRA coverage under this section, you may convert to a plan of individual coverage as described below.

Coverage During an FMLA Leave of Absence

If you are taking an approved leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you, your spouse and your Dependent children will continue to be covered under this Program provided you were eligible when the leave began and you make the required contributions during your leave. Coverage will be continued while you are absent from work on an FMLA leave as if there were no interruption of active employment and as if you were continuing to work the number of hours required for coverage. Coverage will continue until the earlier of the expiration of the FMLA leave or the date you give notice to the State of California Department of Personnel Administration that you do not intend to return to work at the end of the FMLA leave. If you do not return to work at the end of an FMLA leave, the end of the leave will be treated as a Qualifying Event for purposes of COBRA coverage for you, your spouse and your Dependent children who were covered under this Program immediately before the leave began. You, your spouse and your Dependent children may also be entitled to certain rights under the California Family Rights Act (CFRA). A leave protected by the CFRA may run concurrently with an FMLA-protected leave. Pursuant to the Trust's policy, the Program will also provide your domestic partner and your domestic partner's children, as defined in Section IV below, with the same rights as a spouse and Dependent child under the FMLA or CFRA.

Upon your return to work following a leave of absence that qualifies under the FMLA, your coverage will be reinstated as of the date of your return. You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Coverage Under the Uniform Services Employment and Re-Employment Rights Act of 1994

If you voluntarily or involuntarily serve in the uniformed services for a period of 30 days or less while covered under the Program, you, your spouse and your Dependent children are entitled to continue dental coverage at the same cost as employees who are not on a USERRA-protected leave of absence. If you voluntarily or involuntarily serve in the uniformed services for a period that is between 31 days and five years while covered under the Program, you may elect for yourself, your spouse and your Dependent children to continue dental coverage for the lesser of (a) the 24 month period beginning on the date your absence begins or (b) the period beginning on the date your absence begins and ending on the date you fail to apply for or return to work as provided under Sections 1002.115-123 of the Regulations Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"); this period of coverage will run concurrently with COBRA coverage and is conditioned on the timely payment of 102% of the cost of coverage. Pursuant to the Trust's policy, the Program will also provide you with the right to elect to continue coverage for your domestic partner

and your domestic partner's children, as defined in Section IV below, in accordance with the USERRA regulations.

Uniformed service includes all categories of military training and service, including duty performed on a voluntary or involuntary basis, in time of peace or war and includes the following:

- active duty;
- active or inactive duty for training;
- National Guard duty under Federal statute;
- intermit tent disaster-response appointee upon activation of the National Disaster Medical System or a participant in an authorized training program; and
- absences needed to determine the fitness for duty in the uniformed service.

Coverage will end if you are discharged from the service under other than honorable conditions, or if you are dismissed or dropped from the rolls under conditions that result in loss of reemployment rights under the applicable law.

Following continuation of coverage under this section, you may convert to a plan of individual coverage as described below.

If you return to work, coverage for you and your Eligible Dependents may be reinstated if (a) you gave the Trust advance written or verbal notice of your uniformed service leave, and (b) the duration of all uniformed service leave does not exceed 5 years.

If you do not elect USERRA continuation coverage upon leaving or if you elect such continuation coverage but do not make any required contributions, your coverage will be cancelled. If you do not elect USERRA continuation coverage before leaving you may be entitled to retroactive reinstatement under the following conditions:

- If you did not give the Trust advance written or verbal notice of your uniformed service because you were excused from giving such notice as it was impossible, unreasonable or precluded by military necessity, you may elect at any time to have your coverage reinstated retroactively to the date your absence began upon your payment of any unpaid amounts due, if any.
- If you gave the Trust advance written or verbal notice of your uniformed service, you may elect to have your coverage reinstated retroactively to the date your absence began upon your payment of any unpaid amounts due, if any. You may elect such retroactive reinstatement (a) within the period established by the Trust or (b) if a period has not been established by the Trust then within the 24 month period beginning on the date your absence begins.

The election and payment procedures applicable to COBRA

coverage, as described above, will be used for USERRA continuation coverage under this section. Please contact the Trust Office for more information on these procedures.

Individual Continuation of Benefits

A. Loss of Eligibility — If you become ineligible for coverage under the Program, you may apply within 30 days of notice of ineligibility to continue dental coverage. The terms and conditions under the Agreement in which you were enrolled shall continue in effect with the following exceptions: notices and distribution of materials as required will be delivered directly to you; the applicable monthly premium in effect at the time Western Dental approves your application to continue coverage will be paid by you. Such extension of coverage shall apply to your Dependent(s) upon the same terms and conditions as applied to you. Such application may be accepted or rejected at the option of Western Dental: no automatic right of individual continuation of benefits exists.

B. Loss of Eligibili t y Due to Termination of Agree- ment — Western Dental reser ves the right to of fer conversion privileges to you and your Dependents if you become ineligible due to the termination of the Agreement. Should such conversion be offered to you and your Dependents, application must be made by you within 30 days of notice of ineligibility to continue dental coverage. The terms and conditions under the Agreement in which you were enrolled shall continue in effect with the following exceptions: notices and distribution of materials as required will be delivered directly to you; the applicable monthly premium in effect at the time Western Dental approves your application to continue coverage will be paid by you. Such extension of coverage shall apply to your Dependent(s) upon the same terms and conditions as applied to you.

C. Conversion Upon Death or Divorce of Participant — If your spouse or domestic partner who is enrolled in the Program ceases to be an Eligible Dependent by reason of the termination of your marriage or domestic partnership or your death, your spouse or domestic partner will be afforded the same conversion rights and conditions granted to you.

IV. DEFINITIONS

A. "AGREEMENT" means the Group Subscriber Agreement between the Trust and Western Dental.

B. "CCPOA" means California Correctional Peace Officers Association.

C. "COBRA" refers to the federal Consolidated Omnibus Budget Reconciliation Act of 1986, enacted April 7, 1986.

D. "CO-PAYMENT" means the fee charged to a Participant, by the Professional Provider, as described in this Evidence of Coverage, the Agreement, and the Schedule of Benefits.

E. "COVERED SERVICES" means those ser vices and supplies set forth in the American Dental Association's "Uniform Code of Dental Procedures", and described in this Evidence of Coverage and the Schedule of Benefits, when performed and provided by a Participating Provider for the treatment of dental disease, defect or injury which are necessary for the dental health of the Participant in accordance with professionally recognized standards of dental care, and which are rendered for the care and treatment of a nonoccupational accident or condition.

F. "EFFECTIVE DATE" means the date coverage commences under the Program.

G. "ELECTIVE DENTISTRY" means any dental procedures which are unnecessary to the dental health of the patient, as determined by a Professional Provider.

H. "ELIGIBLE DEPENDENT(S)" or "DEPENDENT(S)" as defined in the Program, means an employee's lawful spouse and any dependent of the employee under Internal Revenue Code Section 105(b) who is:

(i) the child of the employee until the end of the month in which the child attains twenty-six (26) years of age, excluding any child who is eligible for coverage as an employee.

(ii) the child of the employee age twenty-six (26) or over who is permanently and totally disabled provided the employee is covered under the Program, provided such child's disability existed continuously prior to age 26 and provided due proof is submitted to Western Dental, which in the sole discretion of Western Dental is sufficient to support a claim that such child meets each of the requirements for a disabled child.

Coverage shall not terminate while a dependent child is and continues to be: (a) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; or (b) Chiefly dependent upon you for support and maintenance.

At least ninety (90) days prior to a child reaching the limiting age, the Plan will send you a notice that coverage for the dependent child will terminate at the limiting age unless proof of incapacity and dependency is provided within sixty (60) days of receipt of notice. The Plan shall determine if the child meets the conditions above, prior to the child reaching the age limit. Otherwise, coverage of the child will continue until the Plan makes its determination. After two (2) years following the child reaching the limiting age, the Plan may request proof of continuing incapacity or dependency, but not more often than yearly.

If you are enrolling a disabled or dependent child for new coverage, the Plan may request initial proof of incapacity and dependency of the child, and then yearly, to ensure the child continues to meet the conditions above. You must provide the

Plan with the requested information within sixty (60) days of receipt of the request. The child must have been covered as a dependent by you or your spouse or domestic partner under a previous health plan at the time the child reached the age limit.

The term "child" includes any natural child, any legally adopted child, any stepchild who resides in the employee's household for more than half of the calendar year, any child under the permanent legal guardianship of the employee or the employee's spouse and who resides in the employee's household. The term "child" also includes any child who must be covered under the Program because of a Qualified Medical Child Support Order (even if that child is not a dependent under Internal Revenue Code Section 105(b)).

Unless other wise excluded, "Eligible Dependents" or "Dependents" also include the domestic partner of the employee and the children of the domestic partner (even if that child is not a dependent under Internal Revenue Code Section 105(b)) provided such children are dependent upon you or your domestic partner for support and maintenance. For purposes of the Program, "domestic partner" is defined as two persons of the same sex (or of the opposite sex if at least one opposite sex partner is over the age of 62 and eligible for Medicare) who meet the following requirements:

(i) share a common residence;

(ii) neither is currently legally married to another person nor a member of another domestic partnership;

(iii) not a blood relative to each other any closer than would prohibit legal marriage in the state in which they reside;

(iv) are at least 18 years of age;

(v) are ment ally capable of consenting to the domestic partnership; and

(vi) have filed a valid Declaration of Domestic Partnership with the Secretary of the State of California.

Not withstanding any thing else herein contained, an employee's spouse shall cease to be a Dependent when the employee and spouse become legally separated or divorced. Further, notwithstanding anything else herein contained, an employee's domestic partner shall cease to be a Dependent when the employee and domestic partner terminate their domestic partnership pursuant to applicable State procedures.

I. "Emergency Dental Care" means services to diagnose and treat a dental condition, which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person with no special knowledge of dentistr y could reasonably expect the absence of immediate dental attention could reasonably be expected to result in: (1) placing the health of the individual (or, in the in case of a pregnant

woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment of bodily functions; or (3) serious dysfunction of any bodily organ or part.

J. "EXCLUSION" means any provision of the Program whereby coverage for a specified hazard or condition is entirely eliminated.

K. "LIMITATION" means any provision other than an exclusion which restricts coverage under the Program.

L. "PARTICIPANT" means an employee, Dependent or beneficiary who is eligible to participate in the Program under the eligibility requirement set forth in this Evidence of Coverage under Eligibilit y, who is enrolled in the Program, and for whom Prepayment Fees have been paid to Western Dental.

M. "PARTICIPATING PROVIDER" or "PROFESSIONAL PROVIDER" means the dentist who is employed by or under contract with Western Dental as a General Practitioner and/ or a Specialist.

N. "PERMANENT INTERMITTENT EMPLOYEE" means a rank and file employee who works at a position or appointment in which the employee is to work periodically or for a fluctuating portion of the fulltime work schedule.

O. "PREPAYMENT FEE" means the amount payable each month on a prepayment basis by a Participant or the Trust (or both) to obtain benefits provided under the Agreement.

P. "PREVAILING RATES" means the usual, customary and reasonable charges as filed with the California Dental Association; a copy of such charges is to be kept at the Professional Provider's office.

Q. "PROGRAM" means the Western Dental Services, Inc. program sponsored by the CCPOA Benefit Trust Fund that provides the Covered Services as set forth herein.

R. "SCHEDULE OF BENEFITS" means the list of Covered Services, and the authorized Co-Payment amounts under the Program as set forth in this Evidence of Coverage.

S. "SPECIALIST" means a dentist who is responsible for the Specific Specialized Dental Care of a Participant in one specific field of dentistry such as endodontics, periodontics, pedodontist, oral surgery, or orthodontics where the Par ticipant is referred by a Professional Provider affiliated with Western Dental.

T. "SPECIFIC SPECIALIZED DENTAL CARE" means a treatment plan (dental care) diagnosed and administered to a particular patient, which a patient receives as a result of the referral to a Specialist of Western Dental and/or Professional Provider affiliated with Western Dental.

U. "TRUST" means the CCPOA Benefit Trust Fund.

V. SCHEDULE OF BENEFITS, CO-PAYMENTS & OTHER CHARGES, & EMERGENCY CARE REIMBURSEMENT

SCHEDULE OF BENEFITS

Western Dental agrees to provide Covered Services to you as set forth in this Evidence of Coverage and the Schedule of Benefits that is attached. Such coverage will be provided when necessary for your dental health in accordance with professionally recognized standards of dental practice, subject to the Exclusions, Limitations, and other terms and conditions set out in this Evidence of Coverage Booklet. The Schedule of Benefits establishes the covered dental care services which are available without a Co-payment (designated as "No Charge" in the schedule) and those services for which you are obligated to pay a Co-payment to the Professional Provider. The amount of the Co-payment which the Professional Provider is permitted to charge you for specific dental care services is set forth under the heading "PATIENT CO-PAYMENT".

The following descriptive categories of Covered Services correspond to the categories set forth in the Schedule of Benefits. To locate the specific Covered Services of this Program for a category of services described in the Evidence of Coverage Booklet, refer to the corresponding categor y heading in the Schedule of Benefits. The Principal Limitations and Principal Exclusions are set forth in Sections VI and VII. Please consult these Sections to determine the extent of your Covered Services under this Program.

A. DIAGNOSTIC — Clinical examinations, radiographs, and other diagnostic tools used in conjunction with your health history in order to evaluate necessary dental treatment. Refer to the "Diagnostic" category on your Schedule of Benefits to determine what specific procedures are Covered Services and the applicable Co-payment amounts.

Clinical examinations may include the following:

1. Comprehensive Oral Evaluation — An evaluation of your dental health needs. This includes evaluating and recording your dental and medical history and a general health assessment, including such things as dental caries, missing or un-erupted teeth, restorations, occlusal relationship, periodontal conditions (including periodontal charting), and hard and soft tissue anomalies.

2. Periodic Oral Evaluation — An evaluation performed to determine any changes in your dental and medical health status since a previous evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures.

3. Radiographs/Diagnostic Imaging — Radiographs are primarily for clinical purposes; they represent an important diagnostic aide. A radiographic exam is a combination of periapical, bitewing, panoramic films or

other views selected for you based on need. The number and type of radiographs in any examination will vary according to your dental needs.

4. Pulp Vitality Test — Assessment of vitality of the pulp tissue which occupies the pulp cavity of the tooth.

B. PREVENTIVE — Those procedures that aid in the prevention of dent al and or al disease. Refer to the "Preventive" categor y of your Schedule of Benefits to determine which specific procedures are Covered Services and the applicable Co-payment amounts.

Preventive Services may include the following:

1. Prophylaxis (Adult and Child) — These cleanings include scaling and polishing of the crown portion of exposed teeth in the mouth and is the treatment for the removal of stain, plaque, and calculus (tartar) above the gum line. It is not intended to be treatment for active periodontal disease where subgingival (beneath the gum line) scaling and root planing is usually required.

2. Topical Fluoride Treatment — Application of topical fluoride to aid in the prevention of caries formation.

3. Topical Fluoride Varnish — Application of topical fluoride varnish to aid in the prevention of caries formation for moderate to high carries risk patients.

4. Oral Hygiene Instruction — Instructions for home care. Examples include tooth brushing technique, flossing, and use of special oral hygiene aids.

C. RESTORATIVE SERVICES — Those procedures used to repair and restore the natural teeth to healthy condition. Refer to the "Restorative Services" category of your Schedule of Benefits to determine which specific procedures are Covered Services and the applicable Co-payment amounts.

1. Amalgam and Resin -Based Composite Restorations — Those procedures that include amalgam or resin-based composite restorative material used in order to repair and restore the natural teeth to healthy condition.

2. Crowns — Single Restoration Onl y — Those procedures that include gold, ceramic, porcelain and porcelain fused to metal in covering the tooth.

3. Other Restorative Services:

a) Prefabricated Stainless Steel and Resin Crowns.

b) Sedative filling — Temporary restoration intended to relieve pain.

c) Post and core buildup — Material placed within the root canal or in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.

D. ENDODONTICS — Those procedures that involve treatment

of the pulp, root canal and roots. Refer to the "Endodontics" category of your Schedule of Benefits to determine which specific procedures are included as Benefits and Coverage and the applicable Co-payment amounts.

1. Pulp Capping — Procedure in which exposed or nearly exposed pulp is covered with a dressing that protects the pulp and promotes healing and repair.

2. Pulpotomy — Removal of a portion of the pulp to maintain the vitality of the remaining portion by means of a dressing.

3. Root Canal Therapy — The treatment of diseases and injuries of pulp and the root canal, and placement of the root canal filling.

4. Apicoectomy — A surgical procedure to repair the damages to the root surface.

E. PERIODONTICS — Those procedures that involve the treatment of the gum and bone supporting the teeth and the management of gingivitis (gum inflammation) and periodontitis (gum disease). Refer to the "Periodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and the applicable Co-payment amounts.

1. Periodontal Services (Surgical). The following Periodontal Services (Surgical) are Covered Services

a) Gingivectomy — Removal of part of the gingival margin resulting in exposure of more tooth structure.

b) Osseous Surgery — Surgical procedure involving the reshaping of the bone to achieve a more healthy and physiologic status.

2. Periodontal Services (Non-surgical)

a) Scaling and Root Planing — Instrumentation of the crown and root surface of the teeth to remove plaque, calculus (tar tar), and contaminated connective tissue from these surfaces.

F. PROSTHODONTICS, REMOVABLE — Replacement of lost teeth by a removable prosthesis and the maintenance of those appliances. Refer to the "Prosthodontics (Removable)" category of your Schedule of Benefits to determine which specific procedures are Covered Services and the applicable Co-payment amounts.

1. Space Maintainers — passive appliances designed to prevent tooth movement.

2. Complete and Par tial Dentures — Full or par tial dentures are Covered Services when dentures are necessary for your dental health consistent with professionally recognized standards of dental practice.

3. Tooth Additions and Repair to Existing Dentures — When required because of loss of natural teeth, tooth

addition to existing dentures is covered. Replacement of missing or broken denture teeth, and repairs to the denture base are also covered.

4. Denture Reline and Rebase — The process of refitting a denture by resurfacing the tissue side of the denture, or by replacing the base material of the denture. Relining and rebasing existing dentures are also covered.

5. Interim Prosthesis — A provisional prosthesis designed for use over a limited period of time, after which it will be replaced by a more definitive restoration.

G. PROSTHODONTICS, FIXED (Fixed Partial Dentures or Bridges) — Replacement of lost teeth by fixed prosthesis is a Covered Ser vice. Refer to the "Prosthodontics, Fixed" category of your Schedule of Benefits to determine which specific procedures are Covered Services and their Co-payment amounts.

1. Fixed Partial Denture Pontics (an artificial tooth on the Fixed Partial Denture) and Abutment Crowns (an artificial crown made to support a Fixed Partial Denture, and which is attached to the Fixed Partial Denture Pontic via a retainer) used in the fabrication process of Fixed Par tial Dentures are Covered Services.

2. Fixed Partial Denture Services —

a) Recementation of Fixed Par tial Dentures — Use of adhesive material to reattach a Bridge that is dislodged.

b) Post and Core Buildup — Material placed within the root canal or in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.

H. ORAL SURGERY — Those procedures that involve the extraction of teeth and other surgical procedures as listed in the attached Schedule of Benefits. Oral Surgery procedures not specifically identified in the Schedule of Benefits are not covered. Refer to the "Oral and Maxillofacial Surgery" category of your Schedule of Benefits to determine which specific procedures are Covered Services and the applicable Co-payment amounts.

1. Extractions — Removal of teeth or parts of teeth.

2. Other Surgical Procedures.

I. ORTHODONTIC TREATMENT — The Program's orthodontic benefit covers only basic orthodontic treatment to resolve malocclusion and establish optimal dental and facial esthetics. Orthodontic treatment may involve the transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Program. Refer to the "Orthodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and the applicable Co-payment amounts.

1. Limited Orthodontic Treatment: Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem in which a decision is made to defer or forego more comprehensive therapy. An example of this type of treatment would be treatment in one arch only to correct crowding or for closure of space(s). Limited Orthodontic treatment is a benefit for treatment of Transitional, Adolescent, and Adult Dentition. Limited Orthodontic Treatment is not a Covered Service unless specifically identified in the Schedule of Benefits.

2. Comprehensive Orthodontic Treatment : T he goal of the comprehensive Orthodontic treatment is improvement of the alignment of the teeth, establishment of optimal interdigitation of the upper and lower teeth, and improvement of functional and es the tic r ela tionships of tee th and j aw. Comprehensive Orthodontic treatment is a benefit for treatment of Transitional, Adolescent, and Adult Dentition.

ORTHODONTIC TREATMENT AFTER TERMINATION

If you are receiving Orthodontic treatment at the time you are terminated from the Program, you can continue to receive care from a Participating Provider for the following continuation fee:

If up to 12 months of treatment has been completed at time of termination: $400.00.

If between 12 and 18 months of treatment has been completed at time of termination: $300.00.

If 18 months or more of treatment has been completed at time of termination: $200.00.

The continuation fee is in addition to the original orthodontic treatment Co-Payment as identified on your Schedule of Benefits. This will be your maximum cost unless your treatment extends beyond the normal 24 month period and charges for extended treatment were not included in your original estimate.

If you relocate to an area outside the geographic area served by Western Dental, and you are unable to receive treatment from a Participating Provider, coverage under this program ceases and you will have no fur ther orthodontic benefit from Western Dental. It becomes your obligation to pay the usual and customary fee of the or thodontist where treatment is completed. (Co-payments for retention and post-treatment records are still applicable.)

Orthodontic Services in Excess of 24 Months of Active Care

For standard active orthodontic treatment provided beyond the 24 month period, but before the retention phase of the treatment begins, you are required to pay the participating orthodontist up to $25.00 per month for each additional month of active treatment.

Orthodontic Retention Phase of Care

Retention services include initial fabrication, placement, observation, and adjustments of passive retention appliances for a 24 month period. There is no copayment for retention services.

PREPAYMENT FEES, CO-PAYMENTS AND OTHER CHARGES

Prepayment Fees

Western Dental shall provide or arrange for the provision of Covered Ser vices specified in the Agreement. The Group shall pay the Prepayment Fee set out on the last page of the Schedule of Benefits.

Co-Payments and Other Charges

In addition to the monthly premium, if any, you will pay an additional charge, or "Co-payment" for those procedures listed in the attached "Schedule of Benefits." All Co-payments are paid directly to the Professional Provider.

If referral to a Specialist is required, your Professional Provider will furnish you with a Specialist Referral Form. If and when you receive approval from Western Dental for the referral, the Specialist will provide his service at a reduced fee, or the Co-payment listed in the Schedule of Benefits, if applicable. All Co-payments are paid directly to the Specialist.

PLEASE NOTE: If you request services from any Specialist without presenting the Specialist Referral Form, you will be responsible for the Specialist's full usual fees for any services rendered. All specialty services must be provided by a Professional Provider.

Liability for Payment

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

EMERGENCY CARE REIMBURSEMENT

In the event that you require Emergency Care, you should contact your Participating Provider to schedule an immediate appointment. For urgent dental conditions that occur after hours or on weekends, you should contact the Participating Provider for instructions on how to proceed. If after contacting the Participating Provider you are advised that the Participating Provider is not available, you may obtain Emergency Care from any licensed dentist in the area where such dental emergency occurs. You may contact Western Dental for assistance with obtaining an emergency appointment from a Participating Provider. Treatment by Participating Providers will be provided at the applicable Co-payment listed in the Schedule of Benefits. However, there is a maximum allowable benefit of $50.00 per emergency for Emergency Care provided by a non-Participating Provider. Western Dental requires an itemized statement of services from you that you received from the out-of-network provider within one hundred eighty (180) days from the date of service for verification of benefit reimbursement.

You must include the itemized statement of services, your name, address, Par ticipant ID number, dates of service, treating provider's name, address, and telephone number, and a statement of the problem, and mail it to:

Western Dental Services, Inc.
Attn: Specialty Referrals/Claims Department
P.O. Box 14227
Orange, California 92863

You should retain a copy of the information, and Western Dental will either send you a check or explain any denial within thirty (30) business days of the Western Dental's receipt of your claim.

VI. LIMITATION OF BENEFITS

A. Limitations on Diagnostic and Preventive Benefits:

1. Prophylaxis (cleanings), are limited to two treatments in any 12 consecutive months.

2. Sealants are only covered to the age of 18 and are limited to permanent first and second molars only.

3. Fluoride treatments are a covered benefit up to the age of 18, once every 12 months.

4. Full mouth x-rays are limited to one set every 24 consecutive months.

5. Bite-wing x-rays are limited to not more than one series of four films in any six-month period.

6. Replacement of a restoration is covered only when it is Medically Necessary.

B. Limitation on Basic Benefits:

1. Periodontal treatments (subgingival curettage and root planing) are limited to five (5) quadrants in any 12 consecutive months.

C. Limitations on Crowns, Jackets and Cast Restorations:

1. Crowns, jackets and cast restorations on the same tooth are limited to once every three (3) years.

2. If porcelain or composite is used on molar crowns, the member is responsible for an additional $75 above the set crown copayment.

3. If noble or high noble metal is used on crowns, the member is responsible for an additional $75 above the set crown copayment.

D. Limitations on Prosthodontic Benefits:

1. Full upper and/or lower dentures are not to exceed one each in any three (3) year period. Replacement will be provided for an existing denture or bridge if it is unsatisfactory and cannot be made satisfactory.

2. Partial dentures are not to be replaced within any three (3) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

3. Denture relines are limited to one during any 12 consecutive months.

E. Limitations and Exclusions on Orthodontic Benefits:

1. Orthodontic treatment must be provided by a Western Dental network orthodontist.

2. Benefits cover 24 months of usual and customary orthodontic treatment.

3. The copayment for orthodontic treatment does not include start-up fees. Start-up fees shall not exceed $250. All covered persons are eligible for orthodontic treatment.

4. Start-up fees shall consist of the initial examination, diagnosis and consultation, and the retention phase of treatment, of up to two (2) years maximum. This includes initial construction, placement and adjustments to retainers for a maximum period of two (2) years.

5. Surgical procedures, including extractions, are not included as a covered benefit.

6. There are no benefits for stolen, lost, or broken appliances.

7. Cephalometric x-rays, tracings, photographs, and study models are not included as a benefit.

8. Myofunctional therapy.

9. Surgical procedures related to cleft palate, micrognathia or macrognathia.

10. Treatment related to Temporomandibular Joint

(TMJ) disturbances and/or hormonal imbalances.

11. Any dental procedure considered within the field of general dentistry such as fillings or extractions.

12. Malocclusions which are so severe or mutilated so as not to be amenable to ideal orthodontic therapy.

13. Treatment that extends 24 months beyond the point of full permanent dentition will be subject to an office visit charge of $25 per office visit.

14. Tooth guidance appliances.

15. Crown exposure and ligation.

16. The are no benefits for a treatment plan which began before the member enrolled in the Plan.

17. If a member relocates to an area and is unable to receive treatment from a Participating Orthodontist, coverage under this program ceases and it becomes the

obligation of the member to pay the usual and customary fee of the orthodontist where the treatment is completed.

Additional charges (at the Or thodontist 's Usual and Customary Fee) will be made for:

1. Initial diagnostic work up and x-rays.
2. Cephalometric x-rays and tracings.
3. Photographs.
4. Study models.
5. Extractions for orthodontic purposes.
6. Pre-banding devices, appliances or therapy.
7. Tooth guidance appliances.
8. Crown and exposure ligation.
9. Orthodontic consultation if the member does not accept treatment plan.
10. Missed appointments (without 24 hours notice).
11. Lost or broken bands.
12. Lost or broken headgear.
13. Headgear.
14. Retainers after the 24 month treatment period has expired.
15. Gross non-cooperation.

VII. EXCLUSION OF BENEFITS

The following services are not covered benefits:

1. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Ser vices, which are provided to the enrollee by State government, or agency thereof, are provided without cost to the enrollee by any municipality, county or other subdivisions.
2. Elective or cosmetic dental care.
3. Temporomandibular Joint (TMJ)
4. Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or extraction solely for orthodontic purposes.
5. Treatment of malignancies, cysts, neoplasms, or congenital malformations.
6. Hospital charges of any kind.
7. Loss or theft of dentures or bridgework.
8. Dispensing of drugs not normally supplied in a dental office.
9. General anesthesia and the services of a special

anesthesiologist.

10. Treatment required by reason of war.

11. Dental expenses incurred in connection with any dental procedure star ted af ter termination of eligibility for coverage.

12. Dental expenses incurred in connection with any dental procedure star ted prior to eligibilit y for coverage.

13. Any ser vice that is not specifically listed as a covered expense.

14. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limits of the enrollee.

15. Fees incurred for missed appointment or failure to notify panel dentist of cancellation 24 hours prior to appointment.

16. Any procedure of an experimental nature.

17. Ser vices which are reimbursable by insurance or reimbursable under any other group or health service plans. Services shall be provided at the time of need, but the member shall execute shuch documents as necessary to assure reimbursement for such benefits.

18. Any procedure per formed for the purpose of correcting contour, contact or occlusion. Any procedure to correct tooth structure lost due to attrition, erosion or abrasion.

19. A Participating Dentist may refuse treatment to any member who continually fails to follow a prescribed course of treatment.

20. If the member and Participating Provider elect a treatment plan disallowed by Western Dental, further liability for additional treatment on that tooth/teeth will not be assumed.

VIII. COORDINATION OF BENEFITS

The following rules are used to determine which plan is primary and which is secondary for payment. The rules define the "Coordination of Benefits."

A. Patient may be covered as an employee by his/her employer and as a dependent by his/her spouse's employer. The plan that covers the patient as an employee (the policyholder) has primary plan benefits.

B. If a child is covered as a dependent under both parents' coverage (and parents are not separated or divorced), the plan of the parent with the earliest birthday in the calendar year has primary responsibility for plan benefits.

C. If a child of divorced or separated parents is covered

as a dependent under the parents' coverage, benefits are determined in this order:

1. The plan of the parent who has custody of the child.

2. The plan of the spouse of the parent who has custody of the child.

3. The plan of the parent not having custody of the child.

D. The benefits of a program which covers a person as an active employee are determined before those of a program which covers a person as a laid-off or retired employee.

E. If spouses/dependents are covered by Western Dental in another managed care program, the Professional Provider must accept the coverage that best benefits the patient.

F. If none of the above rules determine the order of benefits, the plan which has covered the employee the longest has primary plan benefits.

G. If a patient has a conversion plan with Western Dental, and then obt ains dent al coverage through a new employer, the group Program is billed as if there were no other coverage. The conversion plan is not subject to Coordination of Benefits.

When Western Dental is Primary

Your Professional Provider can:

• Submit to the insurance company on a secondary basis at Prevailing Rates, but indicating the out-of-pocket Program Co-payment for procedures performed.

• Accept payment from the secondary insurance company equal to the patient Program Co-payments.

• Only bill the patient if the insurance pays an amount less than the Program Co-payment. The dentist may bill patient for the Co-payment.

When Western Dental is Secondary

Your Professional Provider can:

• Bill primary coverage for all procedures at Prevailing Rates.

• When Western Dental is secondar y, the dentist is entitled to keep all proceeds from the primar y plan, but must waive the Program Co-payment if the reimbursement exceeds the Co-payment responsibility. However, if the other plan benefit is less than the Co-payment, the dentist or the office may collect the difference from the patient.

IX. CHOICE OF PROVIDER

PLEASE RE AD THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY RECEIVE COVERED SERVICES.

You must receive Covered Services from a Professional Provider within Western Dental's Provider Network. You

may designate any Professional Provider who is available. You should review Western Dental's most current Provider Directory for the Program that covers you to learn who may be available. Once you have designated a Professional Provider, you should contact the Professional Provider to receive Covered Services. You should designate your Professional Provider on your enrollment form. If you do not designate a Professional Provider, Western Dental will do so. If you want to change Professional Providers, you should contact Western Dental's Customer Service Department at (800) 992-3366. If your request is received by Western Dental by the 25th of the month, the transfer will be effective on the first day of the following month. Services provided by a non-participating provider are not covered under the Program.

Some Professional Providers available under this Program are employees of Western Dental. Western Dental pays each Professional Provider who is an employee a set amount for each day he or she works. Western Dental will not pay a bonus to anyone to deny, reduce, limit, or delay the provision of Covered Services that a Participant is entitled to receive.

Sometimes, a Professional Provider will be an independent dentist under contract with the Western Dental. Western Dental pays those Professional Providers based on the agreement reached with them. The amount the Professional Provider will receive might not depend on the nature or amount of services provided to a Participant, as is true with capitation payments. On the other hand, the amount the Professional Provider will receive might depend entirely on the nature and amount of services provided, as happens with fee-for-service payments.

Continuity of Care

Current Participants:

Current Participants may be eligible to temporarily continue receiving Covered Ser vices from a non-Par ticipating Provider for treatment of certain specified dental conditions if the ser vices were being provided by a Par ticipating Provider at the time the provider's contract with Western Dental terminated (i.e. a "terminated provider"). Please call Western Dental's Customer Service Department at (800) 992-3366 to see if you may be eligible for this benefit. You may request a copy of Western Dental's Continuity of Care Policy from Western Dental's Customer Service Department. You must make a specific request to continue under the care of your terminated provider. Western Dental is not required to continue your care with your terminated provider if you are not eligible under Western Dental's Continuity of Care Policy or if Western Dental cannot reach agreement with your terminated provider on the terms regarding your care in accordance with California law.

New Participants:

New Participants may be eligible to temporarily continue receiving Covered Services from a non-Participating Provider for treatment of certain specified conditions if the services were being provided by a non-Participating Provider at the time the

Participant's coverage under the Program became effective. Please call Western Dental's Customer Service Department at (800) 992-3366 to see if you may be eligible for this benefit. You may request a copy of Western Dental's Continuity of Care Policy from Western Dental's Customer Service Department. You must make a specific request to continue under the care of your non-Participating Provider. Western Dental is not required to continue your care with your non-Participating Provider if you are not eligible under Western Dental's Continuity of Care Policy or if Western Dental cannot reach an agreement with your non-Participating Provider on the terms regarding your care in accordance with California law.

Second Dental Opinions

You or a Par ticipating Provider may request a second opinion consultation by writing or calling Western Dental's Customer Service Department at (800) 992-3366. Decisions and notifications regarding requests for second opinion consultations will be rendered within the following time limits: For routine second opinion requests, the decision to approve or deny requests for second opinion consultations will be made within 5 business days of Western Dental's receipt of the request. For urgent requests, the second opinion will be authorized or denied within 72 hours of Western Dental's receipt of the request. The requesting Participating Provider will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to a requesting Participant verbally (when possible) and in writing within 2 business days.

A second opinion consultation may be authorized for surgical procedures, unclear or complex and confusing clinical indications, conflicting test results, the Participating Providers' inability to diagnose your condition, a treatment plan in progress but not improving your condition within an appropriate time period, or your serious concerns about a particular diagnosis or plan of care. A written Explanation of Benefits will be issued to you and your Participating Provider, including the name and location of the second opinion provider if the second opinion is approved. Upon approval, Western Dental will refer you to a Participating Provider. Should there be no available Participating Provider in the appropriate geographical area, Western Dental will refer you to a non-Participating Provider for a second opinion consultation. A Western Dental representative will assist you in scheduling an appointment or will advise you to call and schedule an appointment. The second opinion provider will submit the claim for payment to Western Dental. You are only responsible for the applicable Co-payment as set forth in the Schedule of Benefits. Western Dental will pay any cost in excess of the applicable Co-payment, and will contact the provider rendering the second opinion to advise the provider of Western Dental's payment in excess of the Co-payment.

The second opinion provider will provide you and your Participating Provider with a written narrative report of the

results of your consultation. All treatment must be performed by your Participating Provider for you to receive Covered Services under the Program. This shall not limit your right to transfer to another Participating Provider in order to receive Covered Services under the Program.

X. FACILITIES

A list of Western Dental's par ticipating Professional Providers will be available to you by calling the Customer Service Department. Professional Providers are open during normal business hours as specified in the Participating Provider Directory. Should you have a question regarding the days and/or hours of the Professional Provider's facility, you may write or call either the Professional Provider at the address and telephone number listed in the Provider Directory or Western Dental at the address and telephone number listed in Section XI below.

You may receive Emergency Care after regularly scheduled office hours by calling the local telephone number for the Participating Provider's facility. You will be charged the applicable Co-payment as specified in the Schedule of Benefits.

XI. COMPLAINTS AND DISPUTES

Any information, dispute, or complaint should be directed to Western Dental as follows:

WESTERN DENTAL SERVICES, INC.
530 South Main Street
Orange, CA 92868

Telephone calls should be made to Western Dental at the following number: **(800) 992-3366**

XII. GRIEVANCE PROCEDURES

You are encouraged to contact Western Dental at the telephone number listed above regarding any concerns you may have while obtaining services. Western Dental maintains a grievance process to address these concerns. Complaints or grievances can be made in person, at any Participating Provider's office, by obtaining a grievance form and submitting it to Western Dental, or by submitting the grievance using Western Dental's website at www.westerndental.com. There is a representative at the Participating Provider's office or at Western Dental's corporate office to aid you in filling out the grievance form. Completed grievance forms must be mailed to Western Dental at the address listed above. You will receive acknowledgement of your grievance within 5 days and a written response within 30 days as to the disposition of the grievance.

The California Department of Managed Health Care (the "Department ") is responsible for regulating health care service

plans. If you have a grievance against Western Dental, you should first telephone Western Dental at **1-800-992-3366,** and use Western Dental's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Western Dental, 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 treatment that are experimental, or investigational in nature and payment disputes for emergency or urgent medical ser vices. 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 Depar tment's Internet Website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms, and instructions online.

You may submit a complaint or grievance to the Department for review after you have participated in Western Dental's grievance process for at least 30 days.

If your grievance involves an imminent and serious threat to your health — including but not limited to, severe pain, potential loss of life, limb, or major bodily functions — you may submit the grievance to the Department without waiting 30 days. In such a situation, Western Dental will immediately inform you of your right to notify the Department of the complaint. In such a situation, Western Dental also will provide you and, as appropriate, the Department with a written statement of the status or disposition of the complaint within three days of receipt of the complaint.

The Plan will provide written acknowledgement of receipt of a grievance within five (5) calendar days of receipt of the grievance. The acknowledgement will indicate that the grievance has been received, will include the date of receipt of the grievance, and will indicate the name, telephone number, and address of the plan representative who may be contacted about the grievance.

XIII. ARBITRATION

Any and all disputes of any kind whatsoever, including, but not limited to, claims for dental malpractice (that is as to whether any dental services rendered under the Program were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) bet ween you (including your heirs, successors, or assigns) and Western

Dental, except for claims subject to ERISA, shall be submitted to binding arbitration. Any such dispute will not be resolved

by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Western Dental are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in the California county in which you reside at the time of your initial enrollment, or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, Western Dental may assume all or part of your share of the fees and expenses of JAMS and the arbitrator, provided you submit a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The arbitration decision is final and binding on the parties, and the award may only be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

XIV. BENEFIT CLAIMS AND APPEAL PROCEDURES

Benefits under the Program are provided by Participating Providers under contract with Western Dental in return for monthly fees paid by Western Dental to providers for enrolled Participants. Under normal circumstances, there are no claims involved in this process. However, under certain specific circumstances, there may be a need for you to submit a claim for benefits to Western Dental for payment of charges incurred for emergency treatment, or treatment by a specialist, or for reimbursement for amounts you may have paid to such providers. Note that such charges are still subject to all limitations and exclusions of the Program.

A. Claims

1. Filing a Claim

To file a claim for benefits under this Program, you must obtain a written claim form from

Western Dental Services, Inc.,
530 South Main Street
Orange, CA 92868, (800) 992-3366

Claims are to be submitted to:

Western Dental Services, Inc.,
530 South Main Street
Orange, CA 92868.

2. Authorized Representatives

In the event that you are unable to file a claim or an appeal pursuant to the provisions of this section on your own behalf or if you desire to have someone else act on your behalf with respect to such claim or appeal, you may authorize another individual including, but not limited to, your spouse, domestic partner, union official, or attorney, to act as your authorized representative. Such representative must comply with the claims and appeals procedures described in this section.

3. Timing of Benefit Determination

a. Urgent Care Claims

If you fail to follow the proper procedure when you file an urgent care claim, Western Dental will notify you of the improper filing and how to correct it within twenty-four (24) hours after the claim was received.

For an urgent care claim that is filed in accordance with the proper procedure, Western Dental must notify you of the initial decision within seventy-two (72) hours from the time of receipt of a proper initial claim. The notice of denial may be oral with a written or electronic confirmation to follow within three (3) days. If the initial claim is not complete, Western Dental must notify you within twenty-four (24) hours after receiving the claim stating the information that is necessary to complete the claim. You shall have forty-eight (48) hours to provide the information necessary to complete the claim. Western Dental will notify you of its decision no later than forty-eight (48) hours after Western Dental receives the requested information, or within forty-eight (48) hours after the end of the forty-eight (48) hour deadline for you to provide the required information, whichever is sooner. For urgent care claims involving an extension of an ongoing treatment or a course of treatment over a period of time (i.e., a concurrent care claim that is also an urgent care claim), Western Dental must provide notice of a decision to you within twenty-four (24) hours of the receipt of the claim so long as the claim was made at least twenty-four (24) hours prior to the expiration of the previously approved prescribed period of time or number of treatments.

b. Pre-Service Claims

If you fail to follow the proper procedure when you file a pre-

service claim (other than one that qualifies as an urgent care claim), Western Dental will notify you of the improper filing and how to correct it within five (5) days after the claim was received. For a pre-service claim (other than one that qualifies as an urgent care claim) that is filed in accordance with the proper procedure, Western Dental must notify you of an initial decision within fifteen (15) days of receipt of the initial claim unless an ex tension, of up to fif teen (15) days, is necessary due to matters beyond the control of the Program. If an extension is necessary, you shall be notified of the extension within the initial fifteen (15) days. If an initial claim is determined to be incomplete, Western Dental must notify you within fifteen (15) days of receiving the initial claim what information is required to complete the claim. Once such notification is made, you will have forty-five (45) days to provide the required information. Western Dental will notify you of its decision within fifteen (15) days from the time you provide the required information or from the end of the forty-five (45) deadline for you to provide the required information, whichever is sooner.

c. Post-Service Claims

For post-service claims, Western Dental will notify you within thir ty (30) days of receipt of the initial claim unless an extension of up to fifteen (15) days, is necessary due to matters beyond the control of the Program. If an extension is necessary, you shall be notified of the extension within the initial thirty (30) days. If an initial claim is determined to be incomplete, Western Dental must notify you within fifteen (15) days of receiving the initial claim what information is required to complete the claim. Once such notification is made, you will have forty-five (45) days to provide the required information. Western Dental will notify you of its decision within fifteen (15) days from the time you provide the required information or from the end of the forty-five (45) deadline for you to provide the Required information, whichever is sooner. d. Concurrent Care Claims

If a concurrent care claim is not an urgent care claim, and there is a reduction or termination of the previously approved on-going course of treatment provided over a period of time or number of treatments (other than by Program amendment or termination), you will be notified by Western Dental sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit. To appeal a denial of a concurrent care claim, you must follow the review procedures described below.

4. Notice of Claim Denial

If your claim for benefits is denied in whole or in part, Western Dental will provide you with a notice of the denial that includes the following information:

a. the specific reason or reasons for the adverse determination;

b. reference to the specific Program provision(s) on which

the determination is based;

c. a description of any additional material or information necessar y for you to per fect your claim and an explanation of why such material or information is necessary;

d. a description of the Program's appeal procedure and the time limits applicable to such procedures;

e. a statement regarding your right to bring a civil action under Section ERISA § 502(a) following an adverse benefit determination on appeal;

f. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

g. the denial is based on a medical necessit y or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

B. Right of Appeal

1. Filing an Appeal

If you disagree with Western Dental's determination of your claim, you may appeal the determination to Western Dental or the entity delegated to decide appeals by Western Dental. You may request such a review by sending a letter to Western Dental (at the address stated above) within 180 days of receiving the denial notice. Your request for review must be in writing with the exception of urgent care claim denials which may be appealed either orally or in writing.

2. Rights on Appeal

a. If you file an appeal, you may submit writ ten comments, documents, records, andother information relating to your claim to Western Dental or its delegate. You will also be entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits. Western Dental or its delegate will take into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination. Western Dent al or its delegate will make its determination independent of the initial benefit decision.

b. If you submit an appeal, you have the right to request that Western Dental or its delegate hold a hearing wherein you may present the merits of your appeal. Western Dental may request that you appear at such a hearing. Western Dental has sole discretion to decide whether, in any given instance, a hearing shall be conducted.

c. If the initial claim denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, Western Dental will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. If a health care professional is consulted, such professional shall neither be the individual consulted in connection with the initial denial nor the subordinate of such individual. You may request the identification of any medical or vocational experts whose advice was obtained on behalf of the Program.

d. For a request for a review of an urgent care claim, you have the right to an expedited review process pursuant to which your request for an expedited review may be submitted orally or in writing and all necessary information, including the decision on review, will be transmitted between you and Western Dental by telephone, facsimile, or other available similarly expeditious method.

3. Timing of Benefit Determination on Appeal

Western Dental shall act on your request for a review of a denied claim within the time period specified below based on the claim type. If your claim is denied on review, Western Dental shall give written notice of its decision to you. The time deadlines for each claim type are as follows:

a. Urgent Care Claim on Review

You will be notified by Western Dental of the decision as soon as possible taking into account medical exigencies, but not later than seventy-two (72) hours from receipt of a request for review.

b. Pre-Service Claim on Review

You will be notified by Western Dental of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days from receipt of a request for review.

c. Post-Service Claim on Review

You will be notified by Western Dental of the decision within sixty (60) days from receipt of a request for review.

4. Notice of Denial on Appeal

If Western Dental or its delegate denies your appeal, Western Dental or its delegate will provide you with a notice of the adverse determination that includes the following information:

a. the specific reason or reasons for the denial;

b. a reference to the specific Program provisions on which the denial is based;

c. a statement regarding your entitlement to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

d. a statement describing any voluntary appeal procedures offered by the Program and your right to obtain information about such procedures;

e. a statement of your right to bring an action under ERISA § 502(a);

f. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

g. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

5. Action on Appeal

The decision of Western Dental or its delegate is final, subject to judicial review in accordance with federal law. Such judicial review may not be pursued unless and until the claims and appeals procedures described in this section have been exhausted in accordance with such procedure. You and the Program may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

CCPOA DENTAL PROGRAM

XV. SCHEDULE OF BENEFITS AND COPAYMENTS

	COVERED SERVICES	PATIENT CO-PAYMENT
DIAGNOSTIC (D0100-D0999)		
D0120	Periodic oral evaluation	No Charge
D0140	Limited oral evaluation — problem focused	No Charge
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral examination	No Charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	No Charge
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit)	No Charge
D0180	Comprehensive periodontal evaluation — new or established patient	No Charge
D0210	Intraoral-complete series (including bitewings)	No Charge
D0220	Intraoral-periapical first film	No Charge
D0230	Intraoral-periapical each additional film	No Charge
D0240	Intraoral-occlusal film	No Charge
D0250	Extraoral — first film	No Charge
D0260	Extraoral — each additional film	No Charge
D0270	Bitewing-single film	No Charge
D0272	Bitewings-two films	No Charge
D0273	Bitewings-three films	No Charge
D0274	Bitewings-four films	No Charge
D0277	Vertical bitewings — 7 to 8 films	No Charge
D0330	Panoramic film	No Charge
D0350	Oral/Facial Images	No Charge
D0460	Pulp vitality tests	No Charge
D0999	Unspecified diagnostic procedure, by report — *includes office visit, per visit (in addition to other)*	No Charge
PREVENTIVE (D1000-D1999)		
D1110	Prophylaxis cleaning-adult (2 per year)	No Charge
	Additional prophylaxis cleaning — adult (limit 2 additional per year)	No Charge
D1120	Prophylaxis cleaning-child (2 per year)	No Charge
	Additional prophylaxis cleaning — child (limit 2 per year)	No Charge
D1203	Topical application of fluoride (prophylaxis not included)-child	No Charge
D1204	Topical application of fluoride (prophylaxis not included)-adult	No Charge

D1206	Topical Fluoride Varnish; therapeutic application for moderate to high caries risk patients	No Charge
D1310	Nutritional Counseling for control of dental disease	No Charge
D1320	Tobacco Counseling	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant — per tooth	No Charge
D1510	Space maintainer — fixed — unilateral	No Charge
D1515	Space maintainer — fixed — bilateral	No Charge
D1520	Space maintainer — removable — unilateral	No Charge
D1525	Space maintainer — removable — bilateral	No Charge
D1550	Re-cementation of space maintainer	No Charge

RESTORATIVE (D2000-D2999)

D2140	Amalgam-one surface, primary or permanent	No Charge
D2150	Amalgam-two surfaces, primary or permanent	No Charge
D2160	Amalgam-three surfaces, primary or permanent	No Charge
D2161	Amalgam-four or more surfaces, primary or permanent	No Charge
D2330	Resin-based composite-one surface, anterior	No Charge
D2331	Resin-based composite-two surfaces, anterior	No Charge
D2332	Resin-based composite-three surfaces, anterior	No Charge
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)	No Charge
D2390	Resin-based composite crown, anterior	No Charge
D2520	Inlay — metallic — two surfaces.	$60.00
D2530	Inlay — metallic — three or more surfaces	$60.00
D2542	Onlay — metallic — two surfaces	$50.00
D2543	Onlay — metallic — three surfaces	$50.00
D2544	Onlay — metallic — four or more surfaces	$50.00
D2710	Crown — resin-based composite (indirect)	$50.00
D2712	Crown — ¾ resin-based composite (indirect)	$50.00
D2720	Crown — resin with high noble metal	$50.00
D2721	Crown — resin with predominantly base metal	$50.00
D2722	Crown — resin with noble metal	$50.00
D2740	Crown — porcelain/ceramic substrate	$50.00
D2750	Crown — porcelain fused to high noble metal	$50.00
D2751	Crown — porcelain fused to predominantly base metal	$50.00
D2752	Crown — porcelain fused to noble metal	$50.00
D2780	Crown — ¾ cast high noble metal	$50.00

D2781	Crown — ¾ cast predominantly base metal	$50.00
D2782	Crown — ¾ cast noble metal	$50.00
D2790	Crown — full cast high noble metal	$50.00
D2791	Crown — full cast predominantly base metal	$50.00
D2792	Crown — full cast noble metal	$50.00
D2794	Crown — titanium	$50.00
D2910	Recement inlay, onlay, or partial coverage restoration	No Charge
D2915	Recement cast or prefabricated post and core	No Charge
D2920	Recement crown	No Charge
D2930	Prefabricated stainless steel crown - primary tooth	No Charge
D2931	Prefabricated stainless steel crown — permanent tooth	No Charge
D2932	Prefabricated resin crown	No Charge
D2940	Sedative filling	No Charge
D2950	Core buildup, involving and including any pins	No Charge
D2951	Pin retention-per tooth in addition to restoration	No Charge
D2952	Post and core in addition to crown, indirectly fabricated	No Charge
D2953	Each additional indirectly fabricated post — same tooth	$40.00
D2954	Prefabricated post and core in addition to crown	No Charge
D2957	Each additional prefabricated post — same tooth	No Charge
D2970	Temporary crown (fractured tooth) — palliative treatment only	No Charge
	Porcelain on molar restorations (additional charge — per unit)	$75.00
	Noble metal, high noble metal, and titanium, (additional charge — per unit)	$75.00

ENDODONTICS (D3000-D3999)

D3110	Pulp cap-direct (excluding final restoration)	No Charge
D3120	Pulp cap-indirect (excluding final restoration)	No Charge
D3220	Therapeutic pulpotomy (excluding final restoration)-	No Charge
D3310	Anterior (excluding final restoration)	$20.00
D3320	Bicuspid (excluding final restoration)	$30.00
D3330	Molar (excluding final restoration)	$30.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$20.00

D3346 Retreatment of previous root canal therapy—anterior $20.00

D3347 Retreatment of previous root canal therapy—bicuspid $30.00

D3348 Retreatment of previous root canal therapy—molar $30.00

D3351 Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.) ..... No Charge

D3352 Apexification/recalcification—interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc. ..... No Charge

D3353 Apexification/recalcification—final visit (includes completed root canal therapy—apical closure/calcific repair or perforations, root resorption, etc.) ..... No Charge

D3410 Apicoectomy/periradicular surgery—anterior ..... No Charge

D3421 Apicoectomy/periradicular surgery—bicuspid (first root) ..... No Charge

D3425 Apicoectomy/periradicular surgery—molar (first root) ..... No Charge

D3426 Apicoectomy/periradicular surgery—(each additional root) ..... No Charge

D3430 Retrograde filling-per root ..... No Charge

D3450 Root amputation—per root ..... No Charge

PERIODONTICS (D4000-D4999)

D4210 Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant…. ..... No Charge

D4211 Gingivectomy or gingivoplasty-one to three contiguous teeth or bounded teeth spaces per quadrant ..... No Charge

D4240 Gingival flap procedure, including root planing four or more contiguous teeth or bounded teeth spaces per quadrant $20.00

D4241 Gingival flap procedure, including root planing, one to three contiguous teeth or bounded teeth spaces, per quadrant…. $20.00

D4260 Osseous surgery (including flap entry and closure)—four or more contiguous teeth or bounded teeth spaces, per quadrant $20.00

D4261 Osseous surgery (including flap entry and closure)—one to three contiguous teeth or bounded teeth spaces, per quadrant $150.00

D4341 Periodontal scaling and root planing, four or more teeth, per quadrant ..... No Charge

D4342 Periodontal scaling and root planing, one to three teeth, per quadrant ..... No Charge

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	No Charge

PROSTHODONTICS (Removable) (D5000-D5999)

D5110	Complete denture-maxillary	$65.00
D5120	Complete denture-mandibular	$65.00
D5130	Immediate denture-maxillary	$65.00
D5140	Immediate denture-mandibular	$65.00
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	$60.00
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)	$60.00
D5213	Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$60.00
D5214	Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$60.00
D5281	Removable unilateral partial denture — one piece cast metal (including clasps and teeth)	$50.00
D5410	Adjust complete denture-maxillary	No Charge
D5411	Adjust complete denture-mandibular	No Charge
D5421	Adjust partial denture-maxillary	No Charge
D5422	Adjust partial denture-mandibular	No Charge
D5510	Repair broken complete denture base	No Charge
D5520	Replace missing or broken teeth-complete denture (each tooth)	No Charge
D5610	Repair resin denture base	No Charge
D5620	Repair cast framework	No Charge
D5630	Repair or replace broken clasp	No Charge
D5640	Replace broken teeth-per tooth	No Charge
D5650	Add tooth to existing partial denture	No Charge
D5660	Add clasp to existing partial denture	No Charge
D5710	Rebase complete maxillary denture	$20.00
D5711	Rebase complete mandibular denture	$20.00
D5720	Rebase maxillary partial denture	$20.00
D5721	Rebase mandibular partial denture	$20.00
D5730	Reline complete maxillary denture (chairside)	No Charge
D5731	Reline complete mandibular denture (chairside)	No Charge
D5740	Reline maxillary partial denture (chairside)	No Charge
D5741	Reline mandibular partial denture (chairside)	No Charge
D5750	Reline complete maxillary denture (laboratory)	$15.00
D5751	Reline complete mandibular denture (laboratory)	$15.00
D5760	Reline maxillary partial denture (laboratory)	$15.00
D5761	Reline mandibular partial denture (laboratory)	$15.00

D5820	Interim partial denture (maxillary)	$40.00
D5821	Interim partial denture (mandibular)	$40.00
D5850	Tissue conditioning, maxillary	No Charge
D5851	Tissue conditioning, mandibular	No Charge

IMPLANT SERVICES (D6000-D6199)

D5862	Precision Attachment, by report	$410.00
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	$225.00
D5875	Modification of removable prosthesis following: Implant surgery	$311.00
D5982	Surgical stent	$269.00
D6010	Surgical placement of implant body: endosteal implant	$1,169.00
D6053	Implant/abutment supported removable denture for completely edentulous arch	$1,080.00
D6055	Dental implant supported connecting bar	$990.00
D6056	Prefabricated abutment — includes placement	$383.00
D6057	Custom abutment — includes placement	$473.00
D6058	Abutment supported porcelain/ceramic crown	$711.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$719.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$621.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$671.00
D6062	Abutment supported cast metal crown (high noble metal)	$719.00
D6065	Implant supported porcelain/ceramic crown	$801.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$780.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$757.00
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$149.00
D6090	Repair implant supported prosthesis, by report	$494.00
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$359.00
D6092	Recement implant/abutment supported crown	$89.00
D6093	Recement implant/abutment supported fixed partial denture	$131.00
D6094	Abutment supported crown (titanium)	$719.00
D6095	Repair implant abutment, by report	$359.00

D6199 Unspecified implant procedure, by report $338.00
Porcelain on molar restorations
(additional charge) ..... $75.00 per unit
Noble metal, high noble metal, and
titanium (additional charge) ..... $75.00 per unit

PROSTHODONTICS (Fixed) (D6200-D6999)

D6205 Pontic — indirect resin based composite not to be used as a temporary or provisional prosthesis $50.00
D6210 Pontic — cast high noble metal $50.00
D6211 Pontic — cast predominantly base metal $50.00
D6212 Pontic — cast noble $50.00
D6214 Pontic — titanium $50.00
D6240 Pontic — porcelain fused to high noble metal $50.00
D6241 Pontic — porcelain fused to predominantly base metal $50.00
D6242 Pontic — porcelain fused to noble metal $50.00
D6250 Pontic — resin with high noble metal ..... No Charge
D6251 Pontic — resin with predominantly base metal ..... No Charge
D6252 Pontic — resin with noble metal ..... No Charge
D6545 Retainer — Cast metal for resin bonded fixed proshesis $25.00
D6710 Crown — indirect resin based composite $50.00
D6720 Crown — resin with high noble metal ..... No Charge
D6721 Crown — resin with predominantly base metal ..... No Charge
D6722 Crown — resin with noble metal ..... No Charge
D6750 Crown — porcelain fused to high noble metal $50.00
D6751 Crown — porcelain fused to predominantly base metal $50.00
D6752 Crown — porcelain fused to noble metal $50.00
D6780 Crown — ¾ cast high noble metal $50.00
D6781 Crown — ¾ cast predominantly base metal $50.00
D6782 Crown — ¾ cast noble metal $50.00
D6790 Crown — full cast high noble metal $50.00
D6791 Crown — full cast predominantly base metal $50.00
D6792 Crown — full cast noble metal $50.00
D6794 Crown — titanium $50.00
D6930 Recement fixed partial denture ..... No Charge
D6940 Stress breaker ..... No Charge
D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated $40.00
D6972 Prefabricated post and core in addition to fixed partial denture retainer ..... No Charge
D6973 Core build up for retainer, including any pins ..... No Charge

D6976	Each additional indirectly fabricated post—same tooth	$40.00
D6977	Each additional prefabricated post—same tooth	No Charge
D6980	Fixed partial denture repair, by report	No Charge
	Porcelain on molar restorations (additional charge)	$75.00 per unit
	Noble metal, high noble metal, and titanium (additional charge)	$75.00 per unit

ORAL AND MAXILLOFACIAL SURGERY (D7000-D7999)

D7111	Coronal remnants—deciduous tooth	No Charge
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Charge
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No Charge
D7220	Removal of impacted tooth—soft tissue	No Charge
D7230	Removal of impacted tooth—partially bony	No Charge
D7240	Removal of impacted tooth—completely bony	No Charge
D7241	Removal of impacted tooth—completely bony, with unusual surgical complications	$10.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Charge
D7285	Biopsy of oral tissue—hard (bone, tooth)	No Charge
D7286	Biopsy of oral tissue—soft (all others)	No Charge
D7310	Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant	No Charge
D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	No Charge
D7320	Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant	No Charge
D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	No Charge
D7450	Removal of benign odontogenic cyst or tumor—Lesion diameter up to 1.25 cm	No Charge
D7451	Removal of benign odontogenic cyst or tumor—Lesion diameter greater than 1.25 cm	No Charge
D7471	Removal of lateral exostosis (maxillar or mandible)	No Charge
D7472	Removal of torus palatinus	No Charge
D7473	Removal of torus mandibularus	No Charge
D7510	Incision and drainage of abscess-intraoral soft tissue	No Charge

D7960	Frenulectomy (frenectomy or frenotomy) — separate procedure	No Charge
D7963	Frenuloplasty	No Charge

ORTHODONTICS (D8000-D8999)

D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,000.00
D8660	Pre-orthodontic treatment visit	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	No Charge
	Start-up fees	$250.00
	Ortho visits beyond 24 months active treatment or retention	$25.00 per visit

ADJUNCTIVE SERVICES (D9000-D9999)

D9110	Palliative (emergency) treatment of dental pain minor procedure	No Charge
D9210	Local anesthesia not in conjuction with Operative or surgical procedures	No Charge
D9211	Regional block anesthesia	No Charge
D9215	Local anesthesia	No Charge
D9310	Consultation — (diagnostic service provided by dentist or physician other than requesting dentist of physician)	No Charge
D9430	Office visit for observation (during regularly scheduled hours) no other services performed	No Charge
D9440	Office visit-after regularly scheduled hours	No Charge
	Unspecified adjunctive procedure, by report — includes failed appointment without 24 hours notice	$5.00
Zoom! Whitening		$199.00
Clear braces (in addition to orthodontic treatment)		$335.00
Invisalign (total copayment)		$3,500.00

The patient charge for orthodontics is determined from the SCHEDULE OF CO-PAYMENTS. Any down payments and amounts to be paid monthly by you based on this charge will be decided between the orthodontist and you.

XVI. YOUR RIGHTS UNDER ERISA AND SUMMARY PLAN DESCRIPTION

A. Name of Program

The program is known as the Western Dental Program.

The Program is a component of the CCPOA Benefit Trust Fund Health and Welfare Plan ("Plan").

B. Name, Address, and Telephone Number of Plan Sponsor:

The Plan sponsor is:

Board of Trustees
CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, California 95833
916-779-6300 or 800-468-6486

C. Name, Address, and Telephone Number of Plan Administrator:

The Plan is administered by a Board of Trustees, the name, address, and telephone number of which is:

Board of Trustees
CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, California 95833
916-779-6300 or 800-468-6486

The Plan Administrator has the discretionary authority to interpret the terms of the Program, and determine eligibility for benefits. The Plan Administrator may delegate this authority to one or several plan administrators, which may be insurance companies or other appropriate fiduciaries named in this document. The Plan Administrator has delegated its discretionary authority to Western Dental with respect to the interpretation of Program terms regarding these benefits and the denial, granting, and administration of claims and appeals for these benefits. The Plan Administrator is neither the fiduciary for nor the claims administrator of these benefits as those terms are defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended from time to time. With regard to these benefits, Western Dental has the exclusive responsibility for full and final determination as to eligibility and plan interpretation.

As to benefit determinations, the decision of Western Dental is final. Western Dental is solely financially responsible for the payment of benefits under the Program.The procedures governing claims and appeals of claimdenials under this Program are described in Section XIV of this Program document and Summary Plan Description.

D. Identification Numbers

The Employer Identification Number assigned to the Trust by the Internal Revenue Service is EIN 94-6459649. The Plan Number is 501.

E. Type of Program

The Program can be described as an insured welfare benefit plan providing dental benefits. The benefits are insured by:

Western Dental Services, Inc.,
P.O. Box 14227 Orange, California 92683.
1-800-417-4444 or
1-800-992-3366 (Customer Service).

F. Type of Administration

The Program is administered by the Board of Trustees of the CCPOA Benefit Trust Fund. The Board of Trustees has delegated discretionary authority over administration of the Program to Western Dental as described in item C above. The Board of Trustees' address and telephone number are listed in item C above.

G. Name and Address for Agent for Service of Process

The agent for purposes of accepting service of legal process on behalf of the Program is: Board of Trustees CCPOA Benefit Trust Fund c/o 2515 Venture Oaks Way, Suite 200 Sacramento, California 95833 916-779-6300 or 800-468-6486

H. Description of this Program

This Program is a prepaid dental program established pursuant to a collective bargaining agreement and Trust agreement.

I. Participation, Eligibility and Benefits

Participation in the Program is generally open to all CCPOA members, who are employed as full-time, permanent employees and Permanent Intermittent Employees of the State of California Bargaining Unit 6 and their Eligible Dependents. Such Eligible Dependents include lawful spouses and domestic partners as that term is described in Section IV above and certain children under twenty-six (26) years of age as described in Section IV above.

J. Circumstances Which May Result in Ineligibility or Denial of Benefits

Circumstances which may result in disqualification, ineligibility, denial or the loss of benefits include:

1) failure to pay your premiums (if any);
2) voluntary withdrawal;
3) loss of eligibility; or
4) termination of the Program.

The Board of Trustees expressly reserves the right, in its sole discretion, to amend, modify or terminate any type and amount of benefit under this Program at any time (including changing

the amount or payment method of Participant contributions or the eligibility rules for participation). No person has a vested right to any benefit under this Program, and there is no guarantee that the Trust, or any program provided by the Trust will last forever. Termination of the Program together with the termination of the insurance policy(s) which funds the Program benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered dental expense incurred prior to the date that the policy(s) terminate.

K. Source of Contributions

Contributions to this Program are made by the State of California and eligible employees enrolled in the Program through automatic payroll deductions.

L. Entities Used for Accumulation of Assets and Payment of Benefits

The contributions are received by the Board of Trustees which pays prepayment fees to Western Dental, on a monthly basis. Benefits are provided by Western Dental on a capitated basis.

M. End of Plan Year

The Program runs from April 1 to March 31.

N. Statement of Legal Rights

As a Participant in the CCPOA Benefit Trust Fund Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- Examine without charge at the Plan Administrator's office and at other specified locations, such as work sites, all Program documents, including the Memorandum of 65 66 Understanding and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports (Form 5500 series) and plan descriptions, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Program documents and other Program information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each enrollee with a copy of this summary financial report.

- File a suit in a federal court. If any materials requested are not received within 30 days of the enrollee's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The courts may require the Plan Administrator to pay up to $110 for each day's delay until the materials are received.

In addition to creating rights for Program enrollees, ERISA imposes obligations upon the persons who are responsible for the operation of the benefit plan.

These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan enrollees and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Program. No one, including your employer, may fire you or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Program review and reconsider your claim.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you are improperly denied a welfare benefit in whole or in part, you have the right to file suit in a Federal or state court. If you disagree with the Program's decision, or lack thereof concerning a qualified medical child support order, you may file suit in Federal court. If it should happen that Plan Administrators misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim frivolous).

If you have any questions about this statement or your rights under ERISA, you should contact the nearest **Office of the Employee Benefits Security Administration, U.S. Department of Labor, 790 East Colorado Boulevard, Pasadena, California (Phone: 818-583-7862) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210**. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTE: This summary has been designed to provide you with key information about the Program, but it does not provide all the details and limitations of the Program. Exact specifications are provided in the Group Subscriber Agreement. 67

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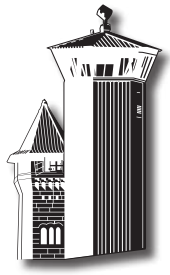
We've Got You Covered.

1-800-In-Unit-6

1-800-468-6486



CCPOA
Benefit Trust Fund

2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

www.ccpoabtf.org

FORM 910-CCPOA (Rev. 03/11)