ASSOCIATION FOR LOS ANGELES DEPUTY SHERIFFS, INC.

January 1, 2009

Prudent Buyer Dental Plan
CERTIFICATE OF INSURANCE

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, California 91367

This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your dental plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Policy, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. Your employer will provide you with a copy of the Group Policy upon request.

Your dental care coverage is insured by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). The following pages describe your health care benefits and includes the limitations and all other policy provisions which apply to you. The insured person is referred to as “you” or “your,” and Anthem Blue Cross Life and Health as “we,” “us” or “our.” All italicized words have specific policy definitions. These definitions can be found in the DEFINITIONS section of this certificate.
COMPLAINT NOTICE

Should you have any complaints or questions regarding your dental coverage, and this certificate was delivered by a broker, you should first contact the broker. You may also contact us at:

Anthem Blue Cross Life and Health Insurance Company
Customer Service
21555 Oxnard Street
Woodland Hills, CA 91367
818-234-2700

or

ASSOCIATION FOR LOS ANGELES DEPUTY SHERIFFS, INC.
Benefit Service Center
9500 Topanga Blvd.
Chatsworth, CA 91311

If the problem is not resolved, you may also contact the California Department of Insurance at:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP (4357) – In California
1-213-897-8921 – Out of California
1-800-482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry: “Consumer Services” link at www.insurance.ca.gov
An insured person enrolled in this dental plan must also be enrolled in the Anthem Blue Cross HMO medical plan or in the Prudent Buyer medical plan, offered under the Agreements between ALADS and Anthem.

This dental plan is insured by Anthem Blue Cross Life and Health Insurance Company, with administrative services provided by Anthem Blue Cross.
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TYPES OF PROVIDERS

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

Participating Dentists. Anthem Blue Cross Life and Health has established a network of various types of "Participating Dentists". These dentists are called "participating" because they have agreed to participate in our preferred dentist organization program (PPO), which we call the Prudent Buyer Plan. They have agreed to provide insured persons with dental care at a negotiated fee.

Participating dentists have agreed not to charge you more than the dental negotiated rate. When you choose a participating dentist, you will not be responsible for any amount in excess of the dental negotiated rate for the covered services of a participating dentist.

We publish a directory of Participating Dentists. You can get a directory from the ALADS Benefit Hotline by calling 1-800-842-6635.

Non-Participating Dentists. Non-participating dentists are dentists which have not agreed to participate in our Prudent Buyer Plan network. They have not agreed to the dental negotiated rates and other provisions of a Prudent Buyer Plan contract.
SUMMARY OF BENEFITS

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE MEDICALLY NECESSARY. THE FACT THAT YOUR DENTIST PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS A MEDICALLY NECESSARY SERVICE OR THAT THE SERVICE IS A COVERED DENTAL EXPENSE.

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your plan.

Second Opinions. If you have a question about your dental condition or about a plan of treatment which your dentist has recommended, you may receive a second dental opinion from another dentist. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this plan. If you wish to receive a second dental opinion, remember that greater benefits are provided when you choose a participating dentist. You may also ask your dentist to refer you to a participating dentist to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this plan may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

DENTAL BENEFITS

DENTAL DEDUCTIBLES

Calendar Year Deductibles
- Insured Person Deductible .................................................................................$50
- Family Deductible .........................................................................................$150

Exception: The Dental Deductible does not apply to Diagnostic and Preventive Services.
PAYMENT RATES

After the Dental Deductible has been satisfied, we will pay the percentage of covered dental expense shown below, for the type of services received, up to the Dental Benefit Maximum:

**Participating Dentists**

- Diagnostic & Preventive Services ................................................. 100%
  (Not subject to the Calendar Year Deductible)
- Restorative Services .......................................................................... 90%
- Oral Surgery ..................................................................................... 90%
- Endodontic Services ........................................................................ 90%
- Periodontic Services ......................................................................... 60%
- Prosthodontic Services (Fixed & Removable) .................................. 60%
- Orthodontic Services ....................................................................... 50%

**Non-Participating Dentists**

- Diagnostic & Preventive Services ..................................................... 100%
  (Not subject to the Calendar Year Deductible)
- Restorative Services .......................................................................... 85%
- Oral Surgery ..................................................................................... 85%
- Endodontic Services ......................................................................... 85%
- Periodontic Services ......................................................................... 50%
- Prosthodontic Services (Fixed & Removable) ................................. 50%
- Orthodontic Services ....................................................................... 50%

**DENTAL BENEFIT MAXIMUMS**

- Calendar Year Maximum ................................................................. $1,500
- Orthodontic Lifetime Maximum ..................................................... $1,500
YOUR DENTAL BENEFITS

We will pay for covered dental expense you incur while covered under this plan, subject to all terms, conditions, limitations and exclusions specified in this certificate.

HOW COVERED DENTAL EXPENSE IS DETERMINED

Covered dental expense is based on a maximum charge for each covered service or supply which we will accept. It is not necessarily the amount a dentist bills for the service.

Covered dental expense will always be the lesser of the billed charge or the amount shown below.

Participating dentists have agreed not to charge you more than the dental negotiated rate. When you choose a participating dentist, you will not be responsible for any amount in excess of the dental negotiated rate for the covered services of a participating dentist.

You will be responsible for any billed charge that exceeds the maximum allowable charge for services provided by a non-participating dentist.

DENTAL DEDUCTIBLES AND BENEFIT MAXIMUMS

After we subtract the Dental Deductible from the total amount of covered dental expense, we will pay benefits at the Payment Rate which applies to such expense, up to the applicable Dental Benefit Maximums. The Deductible amount, Payment Rates, and Dental Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DENTAL DEDUCTIBLES

Only charges that are considered covered dental expense will apply toward satisfaction of the Dental Deductible.

Insured Person Deductible. Each calendar year, you will be responsible for satisfying the Insured Person Deductible before we begin to pay benefits under the plan.

You are not required to satisfy your Dental Deductible before we will pay dental benefits for Diagnostic and Preventive Services.

Covered dental expense incurred during the last quarter of any year and applied toward the Calendar Year Deductible for that year will also count toward the Calendar Year Deductible for the next year.
Family Deductible. If enrolled members of a family pay Deductible expense during a calendar year, equal to the Family Deductible amount shown in the SUMMARY OF BENEFITS, then the Dental Deductible for all insured family members is considered to have been met. No further Dental Deductible is required for the remainder of the year.

DENTAL BENEFIT MAXIMUMS

Calendar Year Maximum. Your benefits, excluding orthodontics, are subject to the Calendar Year Maximum shown in the SUMMARY OF BENEFITS. We will not pay any benefit in excess of that amount for covered dental expense incurred during a calendar year for each insured person. Also, all payments are subject to any waiting periods and limitations specified in this certificate.

Orthodontic Lifetime Maximum. Your orthodontic benefits are subject to the Orthodontic Lifetime Maximum shown in the SUMMARY OF BENEFITS. We will not pay any orthodontic benefits in excess of that amount during an insured person’s lifetime.

DENTAL CONDITIONS OF SERVICE

The following conditions of service must be met for expense incurred to be considered as covered dental expense.

1. You must incur this expense while you are covered for dental benefits under this plan. Expense is incurred on the date you receive the service or supply for which the charge is made.

2. The service must be provided by a licensed dentist, physician, or dental hygienist and must be for preventive care or for treatment of dental disease, defect or injury.

3. The expense must be incurred for a dental service or supply that is included under DENTAL CARE THAT IS COVERED. Additional limits on covered dental expense are included under specific benefits in the SUMMARY OF BENEFITS.

4. The expense must not be for a dental service or supply listed under DENTAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered covered dental expense.

5. The expense must not exceed any of the maximum benefits or limitations of this plan.

6. If we determine that more than one treatment plan would be considered medically necessary for a dental condition, any amount
exceeding the cost of the least expensive professionally acceptable treatment plan is not covered.

PRE-TREATMENT REVIEW

If your dentist anticipates the expense for any course of treatment to exceed $300, you MUST submit a request for a pre-treatment benefit estimation form, which should be prepared by your dentist before any treatment begins. We will review this request and send a copy of our response to the insured person and the dentist.

If you or your dentist disagree with a pre-treatment review decision, you or your dentist may request reconsideration. Any requests for reconsideration (either by telephone or in writing) must be directed to the address and the telephone number included on your written copy of our response.

WAITING PERIODS

There are waiting periods which apply to some of the services listed in YOUR DENTAL BENEFITS: DENTAL CARE THAT IS COVERED. Benefits will not be provided until the waiting periods listed below are met:

**Prosthodontics and Periodontics.** You must be enrolled for dental benefits under this plan for 12 consecutive months to be eligible for benefits for removable or fixed prosthodontics, including inlays and crowns, or for periodontic services.

**Missing Teeth.** You must be enrolled for dental benefits under this plan for 12 consecutive months to be eligible for benefits for partial dentures, complete dentures, or fixed bridges to replace teeth which were missing prior to the effective date of your coverage for dental benefits.

**Exception:** These waiting periods will not apply to any insured person who was covered under a County of Los Angeles sponsored group dental plan immediately before the effective date of coverage of this plan.

DENTAL CARE THAT IS COVERED

Each of the following services or supplies is covered subject to DENTAL CONDITIONS OF SERVICE, provided it meets the requirements explained under HOW COVERED DENTAL EXPENSE IS DETERMINED, and is not for, or in connection with, an exclusion or limitation listed under DENTAL CARE THAT IS NOT COVERED.
Diagnostic and Preventive Services
- Examinations
- X-rays
- Teeth cleaning and fluoride application

Restorative Services
- Fillings

Oral Surgery
- Extractions of teeth and minor oral surgery. (General anesthesia will be covered with the oral surgery if determined to be medically necessary.)

Endodontic Services
- Root canal therapy
- Treatment to prevent or correct conditions that affect the tooth pulp, root and related tissue

Periodontic Services
- Scaling and other procedures to prevent or treat diseases or defects to your gums

Prosthodontic Services (Fixed and Removable)
- Preparation and installation of bridges
- Crowns attached to a bridge
- Crowns not attached to a bridge
- Preparation and installation of partial or complete dentures (including repairs)
- Cast restorations, porcelain inlays

Orthodontic Services
- One case per lifetime
- Consultation
- All adjustments
• All retainers
• 24 months of active orthodontic treatment
• Subject to the Orthodontic Lifetime Maximum shown in the SUMMARY OF BENEFITS

**DENTAL CARE THAT IS NOT COVERED**

No payment will be made under YOUR DENTAL BENEFITS for expense incurred for, or in connection with, any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

**Services Provided Before or After the Term of This Coverage.** Services received before your effective date or during an inpatient hospital stay that began before your effective date. Services received after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

**Experimental or Investigative Procedures.** Any procedures which are considered experimental or investigatory or which are not widely accepted as proven and effective procedures within the organized dental community.

**Medically Necessary.** Any services or supplies which are not medically necessary. (See DEFINITIONS.)

**Workers' Compensation.** Any work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise under any workers' compensation, employer's liability law or occupational disease law, even if you did not claim those benefits.

**Government Programs.** Services provided by, or payment made by, any local, state, county or federal government agency including Medicare and any foreign government agency.

**No Charge Services.** Services received for which no charge is made to you or for which no charge would be made to you in the absence of insurance coverage.

**Results Of War.** Disease contracted or injuries sustained as a result of war, declared or undeclared or from exposure to nuclear energy, whether or not the result of war.

**Provider Related To Insured Person.** Professional services received from a person who lives in your home or who is related to you by blood or marriage.
Excess Expense. Any amounts in excess of covered dental expense or the Dental Benefit Maximums.

Professionally Acceptable Treatment. If more than one treatment plan would be considered medically necessary for a dental condition, any amount exceeding the cost of the least expensive professionally acceptable treatment plan is not covered.

Transfer Of Care. If you transfer from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, we shall be liable only for the amount for which we would have been liable if one dentist had rendered the services.

Hospital Charges. Hospital costs and any additional charges by the dentist for hospital treatment.

Services Not Included as a Covered Procedure. Services not included under DENTAL CARE THAT IS COVERED unless they are similar in nature to an included procedure; in such event the benefit payable will be based on the most nearly comparable services included.

Treatment By An Unlicensed Dentist. Charges for treatment by other than a licensed dentist or physician, except charges for dental prophylaxis performed by a licensed dental hygienist under the supervision and direction of a dentist.

Treatment of the Joint of the Jaw. Diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint) or associated musculature, nerves and other tissues.

Vertical Dimension and Attrition. Procedures requiring appliances or restorations (other than those for replacement of structure lost due to dental decay) that are necessary to alter, restore or maintain occlusion. These include but are not limited to:

- Changing the vertical dimension
- Replacing or stabilizing tooth structure lost by attrition, abrasion, or erosion
- Realignment of teeth
- Gnathological recording
- Occlusal equilibration
- Periodontal splinting
Prosthetic Replacements. Replacement of fixed or removable prosthesis for which benefits were paid, if replacement occurs within five years of the original placement, unless the prosthesis is a stayplate used during the healing period for recently extracted anterior teeth.

Crown Replacements. Replacement of crowns and cast restorations including porcelain crowns and inlays for which benefits were paid by Anthem Blue Cross Life and Health or an affiliated company, if replacement occurs within five years of the original placement.

Denture Repairs, Adjustments or Relines. Repairs, adjustments or relines of full or partial dentures or other prosthesis are not covered for a period of six months from the initial placement if they were paid for under this plan.

Lost or Stolen Dentures or Appliances. Replacement of existing full or partial dentures or prosthetic appliances which have been lost or stolen if replacement occurs within five years of the original placement.

Prosthetics (patients under sixteen years old). Fixed bridges, removable cast partials, cast crowns, with or without veneers, and inlays for patients under sixteen years old.

Implants. Implants (materials implanted into or on bone or soft tissue), or the removal of implants. However, if implants are provided in connection with a covered prosthetic appliance, we will allow the cost of a standard complete or partial denture, or a bridge, toward the cost of the implants and the prosthetic appliances.

Malignancies and Neoplasms. Services for treatment of malignancies and neoplasms.

Cosmetic Dentistry. Any services performed for cosmetic purposes, unless they are for correction of functional disorders or as a result of an accidental injury occurring while you were covered for dental benefits under this plan.

Congenital or Developmental Malformation. Services to correct a congenital or developmental malformation including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (discoloration of the teeth), and anodontia (congenitally missing teeth).

X-rays. More than one set of full-mouth X-rays or its equivalent in a three-year period.

Oral Exams. Oral exams are limited to two per calendar year.
Prophylaxis or Periodontal Prophylaxis. Prophylaxis or periodontal prophylaxis treatments exceeding two treatments in a calendar year. Periodontal prophylaxis must be preceded by active periodontal treatment, such as scaling and root planing or osseous (gum) surgery.

Sealants. Sealants are limited to children under 16 years of age for permanent molars, unrestored. Treatment is limited to once every thirty six (36) months per tooth.

Prescription Drugs and Medications. Any prescribed drugs, pre-medication or analgesia.


ORTHODONTIC CARE THAT IS NOT COVERED

Myofunctional Therapy. Myofunctional therapy and related services. (Myofunctional therapy involves the use of muscle exercises as an adjunct to orthodontic mechanical correction of malocclusion.)

Surgical Procedures Incidental to Orthodontic Treatment. Surgical procedures incidental to orthodontic treatment including, but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.

Orthodontic Services Provided Before or After the Term of Your Coverage. Orthodontic treatment begun prior to your effective date or after the termination of your coverage.

TMJ or Hormonal Imbalance Orthodontic Services. Orthodontic treatment related to temporomandibular joint disturbances (TMJ) and/or hormonal imbalance.

Orthodontic Records. Orthodontic records including, but not limited to, cephalometric tracing, photographs, study models and diagnostic radiographs.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, an insured person may need services under this plan for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this plan subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise,
that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable, but, not more than the amount allowed by California Civil Code Section 3040.

2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your plan. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

**COORDINATION OF BENEFITS**

If you are covered by more than one group dental plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each insured person, per calendar year, and are largely determined by California law.

**DEFINITIONS**

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

**Allowable Expense** is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which we would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

**Other Plan** is any of the following:
1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

**Principal Plan** is the plan which will have its benefits determined first.

**This Plan** is that portion of this plan which provides benefits subject to this provision.

**EFFECT ON BENEFITS**
1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

**ORDER OF BENEFITS DETERMINATION**
The following rules determine the order in which benefits are payable:
1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as an insured member pays before a plan which covers you as a dependent.
3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.
Exception to Rule 3: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:

a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
   i. The plan which covers that child as a dependent of the parent with custody.
   ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).
   iii. The plan which covers that child as a dependent of the parent without custody.
   iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.
OUR RIGHTS UNDER THIS PROVISION

**Responsibility For Timely Notice.** We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

**Reasonable Cash Value.** If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

**Facility of Payment.** If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

**Right of Recovery.** If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.
HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Insured Members.** You are eligible to enroll as an *insured member* if you are one of the following:

   a. An active, full-time peace officer employed by the County of Los Angeles who is eligible to be a member of the Association for Los Angeles Deputy Sheriffs, Inc.

   b. An active, full-time lifeguard employed by the County of Los Angeles.

   c. An active, full-time County Police Officer or Coroner Investigator employed by the County of Los Angeles.

   d. An active, full-time County Police Supervisory or Supervising Coroner Investigator employed by the County of Los Angeles.

   e. An active, full-time employee in Bargaining Unit 614 or 621 employed by the County of Los Angeles.

   f. An active, full-time employee in Bargaining Unit 701 employed by the County of Los Angeles.

   As used above, County of Los Angeles employees are considered to be “active” employees if they consecutively earn their benefit contribution for the current month by being in a continuous “pay status” for at least 8 hours during the prior month.

2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *insured member’s* spouse or domestic partner; and (b) An unmarried child.

Definition of Family Member

1. **Spouse** is the *insured member’s* spouse under a legally valid marriage between persons of the opposite sex.

2. **Domestic partner** is the *insured member’s* domestic partner under a legally registered and valid domestic partnership.

   For a domestic partnership, other than one that is legally registered and valid, in order for the *insured member* to include their domestic...
partner as a family member, the insured member and domestic partner must meet the following requirements:

a. Both persons have a common residence.

b. Neither person is married to someone else nor a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.

c. The two persons are not related by blood in a way that would prevent them from being married to each other in California, or if they reside in another state or commonwealth, that state or commonwealth;

d. Both persons are at least 18 years of age.

e. Both persons are capable of consenting to the domestic partnership.

f. Both partners must provide the group with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.e above, inclusive.

As used above, "have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

3. Child is the insured member’s, spouse’s or domestic partner’s unmarried natural child, stepchild, legally adopted child, or a child for whom the insured member, spouse, or domestic partner has been appointed legal guardian by a court of law, subject to the following:

a. The unmarried child is under 19 years of age, or if age 19 or over, that child is eligible until his or her 25th birthday, provided he or she is enrolled as a full-time student (for 12 or more credits) in a properly accredited two year community college, four year college or university, or an accredited post-high school trade or technical school. Children from age 19 to 25 must also depend on the insured member, spouse or domestic partner for financial support. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes. An unmarried child 19 years of age, but, less than 25 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month
following the date an enrollment application is filed on their behalf.

b. The unmarried child is 19 years of age, or more and: (i) was covered under the prior plan, or has six or more months of creditable coverage, (ii) is chiefly dependent on the insured member, spouse or domestic partner for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 31-days of the date the child first becomes eligible under this plan. After a period of two years has passed from the initial certification to us, we may request proof of continuing dependency and that a physical or mental condition still exists, but, not more often than once each year. This exception will last until the child is no longer chiefly dependent on the insured member, spouse or domestic partner for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the insured member, spouse or domestic partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a hospital, state, or foreign birth certificate (requires notarized translation), legal adoption/placement papers, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child’s birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the insured member, the spouse’s or domestic partner’s right to control the health care of the child.

d. A child for whom the insured member, spouse or domestic partner is a legal guardian is considered eligible on the date of the court decree. Anthem Blue Cross Life and Health must receive legal evidence of the decree. Such child must be enrolled as set forth in the “Enrollment” provision described
below, or will be subject to the "Late Enrollment" requirements described in the "Effective Date" provision.

ENROLLMENT
Every eligible insured member must enroll within 60 days from the eligibility date. The insured member’s eligibility date is the initial date of hire, promotion, appointment or reinstatement of employment with the County of Los Angeles. This initial enrollment must include any eligible family members the insured member wants to cover. The insured member must enroll newly acquired family members with the County of Los Angeles within 90 days from their eligibility date. If any of these steps are not followed, your coverage may be denied.

An insured person enrolled under the policy for dental care benefits must also be enrolled for medical care benefits offered under the Agreement between ALADS and Anthem or ALADS and Anthem Blue Cross HMO. An insured person cannot be enrolled under the policy for dental care benefits only.

EFFECTIVE DATE
Your effective date of coverage is subject to the timely payment of premium charges on your behalf. If this condition has been met, the date on which you become covered is determined as follows:

1. Timely Enrollment for Newly Hired Employees. If you enroll yourself and any eligible family members for coverage within 60 days from your initial eligibility date, then your coverage will begin as follows
   a. For insured members, on the first day of the month following one full month of active employment from the date you file the enrollment application.
   b. For family members, the date the insured member’s coverage begins. The family member’s eligibility date is the date the insured member becomes eligible for coverage.

Exceptions to the Waiting Period
- If, after you have completed the waiting period, you cease to be eligible due to termination of employment, and you return to an eligible status after the date your employment terminated, you will become eligible on the first day of the month following the date you return.
If you were covered under the prior plan, the time you spent under the prior plan will be used to satisfy, or partially satisfy, your waiting period under this plan.

2. Timely Enrollment for Newly Acquired Family Members. If you are enrolled for coverage within 90 days from your eligibility date (e.g., marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child) and if the required documentation is received by the 25th day of any month, then your coverage will begin on the first day of the following month, except for birth, adoption, placement for adoption or legal guardianship. For a newborn child, adopted child, a child placed for adoption or a child for whom the insured member, spouse or domestic partner is a legal guardian, coverage begins as of the date of birth, adoption, placement for adoption or date of the court decree.

3. Late Enrollment. If you file an enrollment application more than 60 days from your eligibility date (or 90 days for newly acquired family members), you must wait until the group's next Annual Enrollment Period to enroll.

4. Disenrollment. If you voluntarily choose to disenroll from coverage under this plan, you will be eligible to reapply for coverage as set forth in the “Enrollment” provision above, during the next annual enrollment period (see ANNUAL ENROLLMENT PERIOD). You may enroll earlier than the next Annual Enrollment Period if you meet the condition listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the insured member, spouse or domestic partner (if the spouse/domestic partner is enrolled) are already covered the following provisions will apply:

1. Any child born to the insured member, spouse or domestic partner will be covered from the moment of birth; and

2. Any child being adopted by the insured member, spouse or domestic partner will be covered from the date on which either:

   a. The adoptive child's birth parent, or other appropriate legal authority, signs a written document granting the insured member, spouse or domestic partner the right to control the health care of the child (in the absence of a written document, other evidence of the insured member's, spouse's or domestic partner's right to control the health care of the child may be used); or

   b. The insured member, spouse or domestic partner assumed a
legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the insured member must enroll the child within 90 days by submitting a Los Angeles County Change Form to the group.

**Special Enrollment Periods**

You may enroll without waiting for the group’s next annual enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
   
   a. You were covered under another dental plan as an individual or dependent, including coverage under a COBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.
   
   b. Your coverage under the other dental plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program’s income or age limits, or you lost no share-of-cost Medi-Cal coverage.
   
   c. You properly enroll with the County of Los Angeles within 90 days from the date on which you lose coverage.

2. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your employee dental plan and an application is filed within 90 days from the date the court order is issued.

3. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:
   
   a. If you are enrolling following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 90 days of the date of marriage or domestic partnership. Your new spouse or domestic partner’s children may also enroll at
that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective on the first day of the month following the date you file the enrollment application.

b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse (if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 90 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, adoption, or placement for adoption.

ANNUAL ENROLLMENT PERIOD

The group has an annual enrollment period once each year, during the month of October. During that time, an individual who meets the eligibility requirements as an insured member under this plan may enroll. An insured member may also enroll any eligible family members at that time. Persons eligible to enroll as family members may enroll only under the insured member’s plan.

For anyone so enrolling, coverage under this plan will begin on the first day of January following the end of the Annual Enrollment Period. Coverage under the former plan ends when coverage under this plan begins.

HOW COVERAGE ENDS

Your coverage ends, without notice from us, as provided below:

1. If the policy terminates, your coverage ends at the same time. The policy may be cancelled or changed without notice to you.

2. If the group no longer provides coverage for the class of insured persons to which you belong, your coverage ends on the effective date of that change. If this policy is amended to delete coverage for family members, a family member’s coverage ends on the effective date of that change.

3. Coverage for family members ends when the insured member’s coverage ends.

4. Coverage ends at the end of the period for which premium has been paid to us on your behalf when the required premium for the next period is not paid.
5. Coverage for a *domestic partner* ends when the domestic partnership ceases to meet the eligibility requirements of a domestic partnership. If a domestic partnership ends, a new *domestic partner* may not be enrolled under this *plan* until the new domestic partnership meets the eligibility requirements.

6. If you voluntarily cancel coverage at any time, coverage ends on the premium due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

7. If you no longer meet the requirements set forth in the "Eligible Status" provision of *HOW COVERAGE BEGINS*, your coverage ends as of the premium due date coinciding with or following the date you cease to meet such requirements.

**Exceptions to Item 7:**

a. **Leave of Absence.** If you are an *insured member* and the *group* pays premium to us on your behalf, your coverage may continue during a temporary leave of absence approved by the *group*.

b. **Handicapped Children.** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) still chiefly dependent on the *insured member*, *spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child has a physical or mental condition that makes them incapable of obtaining self-sustaining employment. We must receive the certification, at no expense to us, within 31 days of the date the *child* otherwise becomes ineligible. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *insured member*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

**Note:** If a marriage or domestic partnership terminates, the *insured member* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the “Eligible Status” provisions. If Anthem Blue Cross Life and Health suffers a loss because of the *insured*
member failing to notify the group of the termination of their marriage or domestic partnership, Anthem Blue Cross Life and Health may seek recovery from the insured member for any actual loss resulting thereby. Failure to provide written notice to the group will not delay or prevent termination of the marriage or domestic partnership. If the insured member notifies the group in writing to cancel coverage for a former spouse or domestic partner and the children of the spouse or domestic partner, if any, immediately upon termination of the insured member’s marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE and EXTENSION OF BENEFITS.
CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the policy is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a period of continuation of coverage. Check with your employer for details.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the “Terms of COBRA Continuation” provisions below.

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this policy as either an insured member or insured family member; and (b) a child who is born to or placed for adoption with the insured member during the COBRA continuation period. Qualified Beneficiary does not include: (a) any person who was not enrolled during the Initial Enrollment Period, including any family members acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a domestic partner, or a child of a domestic partner, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the policy. The events will be referred to throughout this section by number.

1. For Insured Members and Insured Family Members:
   a. The insured member’s termination of employment, for any reason other than gross misconduct;
   b. A reduction in the insured member’s work hours; or
   c. For the purposes of this plan, a labor dispute will be considered a qualifying event under Continuation of Coverage and benefits will be provided under this section.
2. For Insured Family Members:
   a. The death of the insured member;
   b. The spouse’s divorce or legal separation from the insured member;
   c. The end of a child’s status as a dependent child, as defined by the policy; or
   d. The insured member’s entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

An insured member or insured family member, other than a domestic partner, and a child of a domestic partner, may choose to continue coverage under the policy if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The group or its administrator (The ALADS Benefit Service Center) will notify either the insured member or insured family member of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Event 1, the group or its administrator will notify the insured member of the right to continue coverage.
2. For Qualifying Events 2(a) or 2(d) above, a family member will be notified of the COBRA continuation right.
3. You must inform the group within 60 days of Qualifying Events 2(b) or 2(c) above, if you wish to continue coverage. The group, in turn, will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the group within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all insured persons within a family, or only for selected insured persons.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial premium, must be delivered to us by the group within 45 days after you elect COBRA continuation coverage.
Additional Insured Family Members. A spouse or child acquired during the COBRA continuation period is eligible to be enrolled as a family member. The standard enrollment provisions of the policy apply to enrollees during the COBRA continuation period.

Cost of Coverage. The group may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "premium", must be remitted to the group each month during the COBRA continuation period. We must receive payment of the premium each month from the group in order to maintain the coverage in force.

Besides applying to the insured member, the insured member’s premium rate will also apply to:

1. A spouse whose COBRA continuation began due to divorce, separation or death of the insured member;

2. A child, if neither the insured member nor the spouse has enrolled for this COBRA continuation coverage (if more than one child is so enrolled, the premium will be the two-party or three-party rate depending on the number of children enrolled); and

3. A child whose COBRA continuation began due to the person no longer meeting the dependent child definition.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it’s possible for a second Qualifying Event to occur. If that happens, an insured person, who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a child may have been originally eligible for this COBRA continuation due to termination of the insured member’s employment, and was enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the child reaches the upper age limit of the plan, the child is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the premium is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For family members properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the policy.
When the COBRA Continuation Ends. This COBRA continuation will end on the earliest of:

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*

2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the insured member, divorce or legal separation, or the end of dependent child status;*

3. The end of 36 months from the date the insured member became entitled to Medicare, if the Qualifying Event was the insured member’s entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the insured member will end 36 months from the date the insured member became entitled to Medicare;

4. The date the policy terminates;

5. The end of the period for which premiums are last paid;

6. The date, following the election of COBRA, the insured person first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the insured person, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

7. The date, following the election of COBRA, the insured person first becomes entitled to Medicare.

*For an insured person whose COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered insured persons may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled insured person must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

**Notice.** The *insured person* must furnish the *group* with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

**Cost of Coverage.** For the 19th through 29th months that the total disability continues, the *group* must remit the cost for the extended continuation coverage to us. This cost (called the "premium") shall be subject to the following conditions:

1. If the disabled *insured person* continues coverage during this extension, this rate shall be 150% of the applicable rate for the length of time the disabled *insured person* remains covered, depending upon the number of covered dependents. If the disabled *insured person* does not continue coverage during this extension, this charge shall remain at 102% of the applicable rate.
2. The cost for extended continuation coverage must be remitted to us by the *group* each month during the period of extended continuation coverage. We must receive timely payment of the premium each month from the *group* in order to maintain the extended continuation coverage in force.
3. The *group* may require that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The premium rate shall then be 150% of the applicable rate for the 19th through 36th months if the disabled *insured person* remains covered. The charge will be 102% of the applicable rate for any periods of time the disabled *insured person* is not covered following the 18th month.

**When The Extension Ends.** This extension will end at the earlier of:
1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

2. The end of 29 months from the Qualifying Event;

3. The date the policy terminates;

4. The end of the period for which premiums are last paid;

5. The date, following the election of COBRA, the insured person first becomes covered under the other group health plan, unless the other group health plan contains an exclusion or limitation to a pre-existing condition of the insured person, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

6. The date, following the election of COBRA, the insured person first becomes entitled to Medicare.

You must inform the group within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

**SENIOR COBRA CONTINUATION FOR QUALIFYING INSURED PERSONS**

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of premium as stated in the policy, coverage under this plan may be continued for the insured member, the insured member's spouse, and the insured member's former spouse (if any) under Section 10116.5 of the Insurance Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE shown above (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272).

For the purposes of this section, “former spouse” means: (a) an individual who is divorced from the insured member; or (b) an individual who was married to the insured member at the time of the insured member’s death.

**Requirements.** The insured member and spouse may continue coverage under this plan if:

1. The insured member, or the insured member on behalf of himself or herself and the spouse, was entitled to, and had elected to continue coverage under, COBRA, as described in the preceding section;
2. The insured member or spouse has not elected to continue coverage under any other available continuation;

3. The insured member has worked for the employer for at least the prior five years; and

4. The insured member is at least 60 years old on the date employment with the employer ended.

The former spouse may continue coverage under this plan in accordance with this section if he or she was covered as a qualified beneficiary under COBRA, as described in the preceding section.

Notice and Election. The group or its administrator will notify the insured member or spouse and the former spouse of the right to continue coverage within 180 days prior to the date continuation of coverage under COBRA is scheduled to end.

For the insured member and spouse, this continuation may be chosen for both, for the insured member only, or for the spouse only. The former spouse may elect this continuation for himself or herself only.

To elect this continuation, you must notify us in writing within 30 days prior to the date continuation coverage under COBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. You must remit the initial premium to us within 45 days after you elect this continuation.

Cost of Coverage. You are required to pay the entire cost of this continuation coverage. You must remit this cost to us each month during the continuation period. We must receive payment of the premium each month in order to continue the coverage in force. The rate for continuation coverage under this section shall be 213% of the applicable group rate. For the purpose of determining premiums payable, the spouse or former spouse continuing coverage alone will be considered to be an insured member.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. We will bill you for any retroactive charges which may be due. Succeeding premiums are due on the first day of each following month (the Premium Due Date).

Grace Period. For every Premium Due Date, except the first, there is a 31-day grace period in which to pay premiums. If premiums are not received by the end of the grace period, your coverage will be canceled at the end of the period for which premiums are last paid.
**Premium Rate Change.** The premium rates may be changed by us as of any Premium Due Date. We will provide you with written notice at least 30 days prior to the date any premium rate increase goes into effect.

**Accuracy of Information.** You are responsible for supplying accurate, up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide. We can hold you responsible for any loss or expense we incur because of your failure to do so.

**When Continuation Ends.** This continuation will end on the earliest of:

1. The end of the period for which premiums are last paid;
2. The date the policy terminates;
3. The date, following the election of Senior COBRA, the insured member, spouse, or former spouse first becomes covered under any group health plan not maintained by the employer;
4. The date, following the election of Senior COBRA, the insured member, spouse, or former spouse first becomes entitled to Medicare;
5. The date the insured member, spouse, or former spouse reaches age 65; or
6. For the spouse or former spouse, five years from the date the spouse’s or former spouse’s COBRA continuation coverage ended.

**EXTENSION OF BENEFITS**

If you are a totally disabled employee or a totally disabled family member and under the treatment of a dentist on the date of discontinuance of the policy, your benefits may be continued for treatment of the totally disabling dental condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

1. If you wish to apply for total disability benefits, you must do so by submitting written certification by your dentist of the total disability. We must receive this certification within 90 days of the date coverage ends under this plan. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.
2. Your extension of benefits will end when any one of the following circumstances occurs:

   a. You are no longer totally disabled.
   b. The maximum benefits available to you under this plan are paid.
   c. You become covered under another group plan which provides benefits without limitation for your disabling dental condition.
   d. A period of up to 12 months has passed since your extension began.

**GENERAL PROVISIONS**

**Providing of Care.** We are not responsible for providing any type of dental care, nor are we responsible for the quality of such care received.

**Independent Contractors.** Our relationship with providers is that of an independent contractor. Dentists and other dental health professionals are not our agents nor are we or any of our employees, an employee or agent of any dental group or dental care provider of any type.

**Non-Regulation of Providers.** The benefits provided under this plan do not regulate the amounts charged by providers of dental care, except to the extent that rates for covered services are regulated with participating dentists.

**Terms of Coverage**

1. In order for you to be entitled to benefits under the policy, both the policy and your coverage under the policy must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The policy is subject to amendment, modification or termination according to the provisions of the policy without your consent or concurrence.

**Protection of Coverage.** We do not have the right to cancel your coverage under this plan while: (1) this plan is in effect; (2) you are eligible; and (3) your premiums are paid according to the terms of the policy.
Free Choice of Provider. You may choose any dental care professional or facility which provides care covered under this plan, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this plan.

Medically Necessary. The benefits of this plan are provided only for services which are medically necessary. The services must be ordered by the attending dentist for the direct care and treatment of a covered condition. They must be standard dental practice where received for the condition being treated and must be legal in the United States.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this plan.

Benefits Not Transferable. Only insured persons are entitled to receive benefits under this plan. The right to benefits cannot be transferred.

Notice of Claim. You, or someone on your behalf, must give us written notice of a claim within 20 days after you incur covered expense under this plan, or as soon as reasonably possible thereafter.

Claim Forms. After we receive a written notice of claim, we will give you any forms you need to file proof of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you will not have to use these forms, and you may file proof of loss by sending us written proof of the occurrence giving rise to the claim. Such written proof must include the extent and character of the loss.

Proof of Loss. You or the provider of service must send us properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the plan if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

Timely Payment of Claims. Any benefits due under this plan shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.
Payment to Providers. We will pay the benefits of this plan directly to participating dentists. Also, we will pay non-participating dentists directly when you assign benefits in writing. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. When the amount we paid exceeds our liability under this plan, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Plan Administrator - COBRA. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "plan administrator" refers either to the group or to a person or entity, engaged by the group to perform or assist in performing administrative tasks in connection with the group's health plan. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

Workers' Compensation Insurance. The policy does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Entire Contract. This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire policy which includes this certificate. The terms of the policy may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the policy.

Liability For Statements. No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the policy. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

Physical Examination. At our expense, we have the right and opportunity to examine any insured person claiming benefits when and as often as reasonably necessary while a claim is pending.
Legal Actions. No attempt to recover on the *plan* through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this *plan*. No such action may be started later than three years from the time written proof of loss is required to be furnished.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, we will provide benefits at the participating dentist level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a dentist at the time we terminate our contractual relationship with the dentist (unless the dentist’s contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a dentist who voluntarily terminates his or her contract.

You must be under the care of the participating dentist at the time the dentist’s contract terminates. The terminated dentist must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with us prior to termination. The dentist must also agree in writing to accept the terms and reimbursement rates under his or her agreement with us prior to termination. If the dentist does not agree with these contractual terms and conditions, we are not required to continue the dentist’s services beyond the contract termination date.

We will provide such benefits for the completion of covered services by a terminated dentist only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another dentist, as determined by us in consultation with you and the terminated dentist and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the dentist’s contract terminates.
3. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

4. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the dentist's contract terminates.

5. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the dentist to occur within 180 days of the date the dentist's contract terminates.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the plan.

We will notify you by telephone, and the dentist by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the plan. Financial arrangements with terminated dentist's are negotiated on a case-by-case basis. We will request that the terminated dentist agree to accept reimbursement and contractual requirements that apply to participating dentists, including payment terms. If the terminated dentist does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that dentist's services. If you disagree with our determination regarding continuity of care, you may file a complaint with us as described in the COMPLAINT NOTICE.

INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT

If coverage for a proposed treatment is denied because we determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization contracting with the California Department of Insurance ("CDI"). Your request for this review may be submitted to the CDI. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this
reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
  
  ♦ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient’s survival.
  
  ♦ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

- Your dentist must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this plan than the proposed treatment.

- The proposed treatment must either be:
  
  ♦ Recommended by a participating dentist who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  
  ♦ Requested by you or by a licensed board certified or board qualified dentist qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
    
    a) Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
    
    b) Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
    
    c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and

f) Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You are not required to go through our grievance process for more than 30 days. If your grievance needs expedited review, you are not required to go through our grievance process for more than three days.

You must request this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

Within three business days of receiving notice from the CDI of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your dentist. Any newly developed or discovered relevant medical records identified by us or by a participating dentist after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your dentist determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

**INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE**

You may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance ("CDI") if you believe that we have improperly denied, modified, or delayed health care services. A “disputed health care service” is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us, in whole or in part because the service is not medically necessary.
The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form and an addressed envelope for you to use to request IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility: The CDI will review your application for IMR to confirm that:

1. (a) Your dentist has recommended a health care service as medically necessary, or

   (b) You have received urgent care or emergency services that a dentist determined was medically necessary, or

   (c) You have been seen by a participating dentist for the diagnosis or treatment of the medical condition for which you seek independent review;

2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not medically necessary; and

3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The CDI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the CDI must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain,
the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 days.

For more information regarding the IMR process, or to request an application form, please call us at the customer service telephone number listed on your ID card.

**BINDING ARBITRATION**

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or the policy, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The insured person and Anthem Blue Cross Life and Health agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

The insured person and Anthem Blue Cross Life and Health agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the insured person waives any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health waives any right to pursue on a class basis any such controversy or claim against the insured person.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the insured person making written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the insured person and Anthem Blue Cross Life and Health, or by order of the court, if the insured person and Anthem Blue Cross Life and Health cannot agree.
The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross Life and Health will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

DEFINITIONS

The meanings of key terms used in this certificate are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your certificate, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) is the company which insures the benefits of the plan.

Child meets the plan’s eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children’s Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers’ compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the pre-existing condition exclusion period under this plan and/or to set
up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer’s contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this plan is no more than 180 days (not including any waiting period imposed under this plan).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this plan is no more than 63 days (not including any waiting period imposed under this plan).

**Covered dental expense (covered expense)** is the expense you incur for a covered service or supply, but not more than the maximum amounts described in items 1 and 2 below. Expense is incurred on the date you receive the service or supply. Covered dental expense does not include:

1. For all participating dentists, any charge in excess of the dental negotiated rate; or
2. For non-participating dentists, any charge by in excess of the maximum allowable charge.

**Dental negotiated rate** is the amount participating dentists agree to accept as payment in full for covered services. It is usually lower than their normal charge. Dental negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements.

**Dentist** is a person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

**Domestic partner** meets the plan’s eligibility requirements for domestic partners as outlined under **HOW COVERAGE BEGINS AND ENDS**: **HOW COVERAGE BEGINS**.

**Effective date** is the date your coverage begins under this plan.

**Experimental** procedures are those that are mainly limited to laboratory and/or animal research.
**Group** refers to the business entity to which we have issued this *policy*. The name of the group is ASSOCIATION FOR LOS ANGELES DEPUTY SHERIFFS, INC.

**Insured family member (family member)** meets the *plan’s* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

**Insured member (member)** is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *family members*.

**Insured person** is the *insured member* or *insured family member*.

**Investigative** procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

**Maximum allowable charge** is the maximum amount we will allow for a service provided by *non-participating dentist*. When you receive services from a *non-participating dentist*, only the amount of the charge up to the *maximum allowable charge* for the provider’s service will be considered to be *covered expense*. Any part of a charge over the *maximum allowable charge* is excess expense and is not *covered expense*. The *maximum allowable charge* is listed and described in more detail in the MAXIMUM ALLOWABLE CHARGE SCHEDULE.

**Medically Necessary** procedures, services or supplies are those which are:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the dental condition;
2. Customarily provided for the prevention, diagnosis, or direct care and treatment of the dental condition;
3. Within standards of good dental practice within the organized dental community;
4. Not primarily for your convenience, or the convenience of your *dentist* or another provider; and
5. Based on prevailing dental practices, the least expensive covered service suitable for your dental condition which will produce a professionally satisfactory result.

**Non-participating dentist** is a *dentist* which does NOT have a Prudent Buyer Plan Participating Provider Agreement with us at the time services are rendered.
Participating dentist is a dentist which has a Prudent Buyer Plan Participating Agreement in effect with us at the time services are rendered. Participating dentists agree to accept the dental negotiated rate as payment for covered services. A directory of participating dentists is available upon request.

Plan is the set of benefits described in this booklet and in the amendments to this booklet, if any. This plan is subject to the terms and conditions of the policy we have issued to the group. If changes are made to the plan, an amendment or revised booklet will be issued to the group for distribution to each insured member affected by the change.

Policy is the Group Policy we have issued to the group.

Prior plan is a plan previously sponsored by the employer which was replaced by the insured members selection of this plan. An insured person is considered covered under the prior plan if that insured person: (1) was covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 60 days from the prior plans termination; and (3) had coverage terminate solely due to the prior plan's termination.

Spouse meets the plan's eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Totally disabled employee is an employee who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

Totally disabled family member is a family member who is unable to perform all activities usual for persons of that age.

We (us, our) refers to Anthem Blue Cross Life and Health Insurance Company.

Year or calendar year is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the insured member and insured family members who are enrolled for benefits under this plan.
MAXIMUM ALLOWABLE CHARGE SCHEDULE

This section explains how we determine the maximum allowable charge (the maximum amount we will consider covered expense for non-participating dentists) and is subject to the maximums, conditions, exclusions and limitations of this plan.

SERVICE AREAS

A provider’s service area is determined by the area in which the provider’s principal place of business is located.

- **Service Area 1**: Counties of Alpine, Amador, Butte, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yolo and Yuba and parts of Mono and Sonoma. Zip code ranges include: 94200-94299; 95400-96199.

- **Service Area 2**: Counties of Alameda, Contra Costa, Marin, Napa Solano and parts of Monterey and Sonoma. Zip code ranges include: 93900-93999; 94500-94999.

- **Service Area 3**: Counties of San Benito, San Francisco, San Mateo, Santa Clara and parts of Monterey. Zip code ranges include: 94000-94199; 94300-94499; 95000-95199.

- **Service Area 4**: Counties of Los Angeles, Santa Barbara, San Luis Obispo, Ventura, parts of Orange, San Bernardino and Riverside. Zip code ranges include: 00001-89999; 90000-91899; 93000-93199; 93400-93499; 96200-99999.

- **Service Area 5**: Orange County. Zip code ranges include: 92600-92999.

- **Service Area 6**: Counties of Imperial, Inyo, Kern, Kings, Riverside, San Bernardino, parts of Fresno, Mono and Tulare, and parts of Los Angeles, including the cities of Lancaster and Palmdale. Zip code ranges include: 92200-92599; 93200-93399; 93500-93599.

- **Service Area 7**: San Diego County. Zip code ranges include: 91900-92199.

- **Service Area 8**: Counties of Calaveras, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tuolumne, and parts of Fresno and Tulare. Zip code ranges include: 93600-93899; 95200-95399.

- **Service Area 9**: Outside California.
Important Note – The dental regions are defined by zip codes. The list of counties in this table is an attempt to align the zip code ranges with counties and may have discrepancies where the two do not align exactly. The zip code ranges should be considered definitive wherever such discrepancies exist.

CHARGES BY A DENTIST WHO IS A NON-PARTICIPATING DENTIST

1. Charges for services of a dentist who is a non-participating dentist are determined by maximum allowable charge. The maximum allowable charge varies according to the service area of the dentist.

2. To find out what the maximum allowable charge is for services not listed, you may telephone us toll-free at 888-209-7852 and we will tell you what the maximum allowable charge is for those services.

3. The maximum allowable charges listed in the tables in this booklet are only a partial sample listing.

For services provided by a dentist who is a non-participating dentist, covered expense will not exceed the maximum allowable charge which is the most we will consider as covered expense for that service under the plan.

We have developed a maximum allowable charge for covered services. Notice that for each service listed in the table, there is a "Procedure Code" and a maximum allowable charge. Dentists use these Procedure Codes to identify their services for billing purposes. These codes are published by the American Dental Association and are widely used throughout the dental profession.

Your dentist should be able to identify for you which "Procedure Code(s)" applies to the service(s) to be performed. Remember, the maximum allowable charge may be less than the dentist’s charge for such services. You are responsible for paying any amount by which this charge exceeds the maximum allowable charge, in addition to any Deductible and co-insurance required under this plan.

Participating dentists have agreed not to charge any more for their services than the dental negotiated rate, leaving you only the amount of your Deductible and co-insurance described in the SUMMARY OF BENEFITS.
## TABLE OF MAXIMUM ALLOWABLE CHARGES

*(Partial Sample Listing)*

### Service Area 1

<table>
<thead>
<tr>
<th>Procedure Code - Procedure</th>
<th>Maximum Allowable Charge</th>
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<tbody>
<tr>
<td>0120 - Periodic Oral Examination</td>
<td>$29.00</td>
</tr>
<tr>
<td>1110 - Dental Prophylaxis - Adult</td>
<td>58.00</td>
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<tr>
<td>1120 - Dental Prophylaxis - Child (to Age 14)</td>
<td>41.00</td>
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<tr>
<td>2150 - Amalgam - Two Surfaces</td>
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<tr>
<td>2750 - Crown Porcelain Fused to High Noble Metal</td>
<td>591.00</td>
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<tr>
<td>3330 - Root Canal Molar (excluding Final Restoration)</td>
<td>667.00</td>
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<tr>
<td>4341 - Perio Scaling and Root Planning/Quadrant</td>
<td>147.00</td>
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<tr>
<td>5110 - Complete Upper Denture</td>
<td>713.00</td>
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<tr>
<td>6240 - Pontic-Porcelain Fused to High Noble Metal</td>
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<td>7110 - Extraction/Single Tooth</td>
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<tr>
<td>1110 - Dental Prophylaxis - Adult</td>
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**Service Area 3**

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<tr>
<th>Procedure Code - Procedure</th>
<th>Maximum Allowable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0120 - Periodic Oral Examination</td>
<td>$32.00</td>
</tr>
<tr>
<td>1110 - Dental Prophylaxis - Adult</td>
<td>63.00</td>
</tr>
<tr>
<td>1120 - Dental Prophylaxis - Child (to Age 14)</td>
<td>45.00</td>
</tr>
<tr>
<td>2150 - Amalgam - Two Surfaces</td>
<td>93.00</td>
</tr>
<tr>
<td>2750 - Crown Porcelain Fused to High Noble Metal</td>
<td>673.00</td>
</tr>
</tbody>
</table>
High Noble Metal

3330 - Root Canal Molar (excluding Final Restoration)  714.00
4341 - Perio Scaling and Root Planning/Quadrant  143.00
5110 - Complete Upper Denture  969.00
6240 - Pontic-Porcelain Fused to High Noble Metal  666.00
7110 - Extraction/Single Tooth  88.00

Service Area 6

<table>
<thead>
<tr>
<th>Procedure Code - Procedure</th>
<th>Maximum Allowable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0120 - Periodic Oral Examination</td>
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<tr>
<td>1110 - Dental Prophylaxis - Adult</td>
<td>61.00</td>
</tr>
<tr>
<td>1120 - Dental Prophylaxis - Child (to Age 14)</td>
<td>47.00</td>
</tr>
<tr>
<td>2150 - Amalgam - Two Surfaces</td>
<td>84.00</td>
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<tr>
<td>2750 - Crown Porcelain Fused to High Noble Metal</td>
<td>583.00</td>
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<tr>
<td>3330 - Root Canal Molar (excluding Final Restoration)</td>
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<tr>
<td>4341 - Perio Scaling and Root Planning/Quadrant</td>
<td>146.00</td>
</tr>
<tr>
<td>5110 - Complete Upper Denture</td>
<td>786.00</td>
</tr>
<tr>
<td>6240 - Pontic-Porcelain Fused to High Noble Metal</td>
<td>569.00</td>
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<tr>
<td>7110 - Extraction/Single Tooth</td>
<td>84.00</td>
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### Service Area 7

<table>
<thead>
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<tbody>
<tr>
<td>0120 - Periodic Oral Examination</td>
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<tr>
<td>1110 - Dental Prophylaxis - Adult</td>
<td>58.00</td>
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<td>44.00</td>
</tr>
<tr>
<td>2150 - Amalgam - Two Surfaces</td>
<td>91.00</td>
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<tr>
<td>2750 - Crown Porcelain Fused to High Noble Metal</td>
<td>636.00</td>
</tr>
<tr>
<td>3330 - Root Canal Molar (excluding Final Restoration)</td>
<td>627.00</td>
</tr>
<tr>
<td>4341 - Perio Scaling and Root Planning/Quadrant</td>
<td>146.00</td>
</tr>
<tr>
<td>5110 - Complete Upper Denture</td>
<td>923.00</td>
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<tr>
<td>6240 - Pontic-Porcelain Fused to High Noble Metal</td>
<td>633.00</td>
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<tr>
<td>7110 - Extraction/Single Tooth</td>
<td>83.00</td>
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### Service Area 8

<table>
<thead>
<tr>
<th>Procedure Code - Procedure</th>
<th>Maximum Allowable Charge</th>
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</thead>
<tbody>
<tr>
<td>0120 - Periodic Oral Examination</td>
<td>$28.00</td>
</tr>
<tr>
<td>1110 - Dental Prophylaxis - Adult</td>
<td>63.00</td>
</tr>
<tr>
<td>1120 - Dental Prophylaxis - Child (to Age 14)</td>
<td>45.00</td>
</tr>
<tr>
<td>2150 - Amalgam - Two Surfaces</td>
<td>93.00</td>
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<tr>
<td>2750 - Crown Porcelain Fused to High Noble Metal</td>
<td>565.00</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Procedure Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3330 - Root Canal Molar</td>
<td>(excluding Final Restoration)</td>
</tr>
<tr>
<td>4341 - Perio Scaling</td>
<td>and Root Planning/Quadrant</td>
</tr>
<tr>
<td>5110 - Complete Upper</td>
<td>Denture</td>
</tr>
<tr>
<td>6240 - Pontic-Porcelain</td>
<td>Fused to High Noble Metal</td>
</tr>
<tr>
<td>7110 - Extraction</td>
<td>Single Tooth</td>
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</table>

**Service Area 9**

<table>
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<tr>
<th>Procedure Code</th>
<th>Procedure Description</th>
<th>Maximum Allowable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0120 - Periodic Oral Examination</td>
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<td>$26.00</td>
</tr>
<tr>
<td>1110 - Dental Prophylaxis - Adult</td>
<td></td>
<td>61.00</td>
</tr>
<tr>
<td>1120 - Dental Prophylaxis - Child (to Age 14)</td>
<td></td>
<td>47.00</td>
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<tr>
<td>2150 - Amalgam - Two Surfaces</td>
<td></td>
<td>86.00</td>
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<tr>
<td>2750 - Crown Porcelain Fused to High Noble Metal</td>
<td></td>
<td>651.00</td>
</tr>
<tr>
<td>3330 - Root Canal Molar</td>
<td>(excluding Final Restoration)</td>
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</tr>
<tr>
<td>4341 - Perio Scaling</td>
<td>and Root Planning/Quadrant</td>
<td>146.00</td>
</tr>
<tr>
<td>5110 - Complete Upper</td>
<td>Denture</td>
<td>983.00</td>
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<tr>
<td>6240 - Pontic-Porcelain</td>
<td>Fused to High Noble Metal</td>
<td>625.00</td>
</tr>
<tr>
<td>7110 - Extraction</td>
<td>Single Tooth</td>
<td>88.00</td>
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