

## CERTIFICATE OF INSURANCE

**UNICARE Life & Health Insurance Company**  
**PO Box 5347**  
**Oxnard, CA 93031**  
**800-995-4124**

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 UNICARE Life & Health Insurance Company (UNICARE). 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 UNICARE 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

If you or any *insured person* covered under this *plan* have a problem regarding your coverage, please contact UNICARE dental services first to resolve the issue. You may contact us at:

Dental Services  
PO Box 5347  
Oxnard, CA 93031  
800-995-4124

If the problem is not resolved to your satisfaction, 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

## 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.** We have established a network of various types of "Participating Dentists". These dentists are called "participating" because they have agreed to participate in our contracted preferred provider organization network (PPO). They have agreed to provide you with dental care at a negotiated fee. The amount of benefits payable under this *plan* will be different for *non-participating dentists* than for *participating dentists*.

**Non-Participating Dentists.** *Non-participating dentists* are dentists which have not agreed to participate in our contracted preferred provider organization network. They have not agreed to the *negotiated rates* and other provisions of a PPO network contract.

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## HOW COVERAGE BEGINS AND ENDS

### HOW COVERAGE BEGINS

#### ELIGIBLE STATUS

1. **Insured Employees.** Permanent *full-time employees* are eligible to enroll as *insured employees*. A *full-time employee* is one who works at least 30 hours a week in the conduct of the business of the *group*.
2. **Family Members.** The following are eligible to enroll as *family members*: (a) The *employee's spouse or domestic partner*; and (b) An unmarried *child*.

#### Definition of Family Member

1. **Spouse** is the *employee's* spouse under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is: (a) covered as an *insured employee*; or (b) in active service in the armed forces.
2. **Child** is the *employee's* or *spouse's* unmarried natural child, stepchild, or legally adopted child, subject to the following:
  - a. The child depends on the *employee, domestic partner or spouse* for financial support or the *employee, domestic partner or spouse* is legally required to provide group health coverage for the child pursuant to an administrative or court order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.
  - b. The unmarried child is under 19 years of age, or if over the age of 19, that child is eligible until his or her 23rd 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. An overage dependent 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.
  - 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 *employee, domestic partner or spouse* 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 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 *employee's, domestic partner's or the spouse's* right to control the health care of the child.

- d. The term "child" does not include: (i) any child for whom the *employee, domestic partner or spouse* is the legal guardian, but who is not the *employee's, domestic partner's or spouse's* natural child, stepchild or adopted child; (ii) any person who is covered as an *employee*; or (iii) any person who is in active service in the armed forces.
  - e. If both parents are covered as *employees*, their children may be covered as the *family members* of either, but not of both.
3. **Domestic Partner** is defined as the *insured employee's* same sex or opposite sex partner in residence, subject to all of the following conditions:
    - a. They are both 18 years of age or older.
    - b. They share the same regular and permanent residence with the current intent to continue doing so indefinitely.
    - c. They must have either filed a Declaration of Domestic Partnership with the Secretary of State of the state of California in accordance with Section 298.5 of the Family Code; or
    - d. Have been issued an equivalent document by a local agency of California, another state, or a local agency of another state under which the partnership was created; and
    - e. The domestic partnership has not terminated.

The term "they" refers to both the *insured employee* and the domestic partner. Domestic partner does not include any person who is: (a) covered as an *insured employee*; or (b) *spouse*.

#### ELIGIBILITY DATE

1. **For Employees:** Your employer has determined a certain number of days or months you must work in continuous, active full-time employment prior to becoming eligible to apply for group benefits. This is your group eligibility period. You become eligible for coverage on the first day of the month coinciding with or following the date you complete your group eligibility period.
2. **For Family Members:** You become eligible for coverage on the later of: (a) the date the *employee* becomes eligible for coverage; or (b) the date you meet the *family member* definition.

#### ENROLLMENT

To enroll as an *employee*, or to enroll *family members*, the *employee* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 31 days from your eligibility date. If you do not properly file your application, your coverage may be denied.

## EFFECTIVE DATE

Subject to the timely payment of premium on your behalf, your coverage will begin as follows:

1. **Timely Enrollment.** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *employees*, on the first day of the month following your eligibility date; and (b) for *family members*, on the later of (i) the date the *employee's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *policy* takes effect, coverage begins on the effective date of the *policy*.
2. **Late Enrollment.** If you do not enroll within 31 days after your eligibility date, you will be considered a *late entrant* and will only be eligible to receive those dental services listed in Category I Preventive & Diagnostic Dental Services under DENTAL CARE THAT IS COVERED during the first twelve months of coverage. However, you may enroll more than 31 days after your eligibility date without being considered a *late entrant* if you meet the requirements to enroll under SPECIAL ENROLLMENT PERIODS.
3. **Disenrollment.** If you voluntarily choose to disenroll from coverage under this *plan*, and then re-enroll, you will be considered a *late entrant* and will only be eligible to receive those dental services listed in Category I Preventive & Diagnostic Dental Services under DENTAL CARE THAT IS COVERED during the first twelve months of coverage. You may re-enroll without being considered a *late entrant* if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

## SPECIAL ENROLLMENT PERIODS

You may enroll if you are 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.
  - b. You have lost coverage under the other dental plan wherein you were covered as an individual or dependent, or your coverage under a COBRA continuation was exhausted.
  - c. You properly file an application with the *group* within 31 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 application is filed within 31 days from the date the court order is issued.
3. You have a change in family status through either marriage or the birth or adoption of a *child*. You may also enroll a new *spouse*, *domestic partner* or *child* at that time. You must enroll within 31 days of the marriage, birth, or adoption. Coverage will become effective as follows:
  - a. If you are enrolling following marriage, the first day of the month following the date you filed the enrollment application.
  - b. If you are enrolling following the birth or adoption of a *child*, as of the first day of the month following the date of birth or adoption.Your *domestic partner* or *spouse* (if you are already married), who is eligible but not enrolled, may also enroll at the time of the birth or adoption of a *child*. Application must be made within 31 days of the birth or date of adoption; coverage will be effective as of the date of the birth or adoption.

## 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 canceled 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 first day of the month following 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 first day of the month following the effective date of that change.
3. Coverage for *family members* ends when the *employee'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. 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.
6. 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 6:

- a. **Leave of Absence.** If you are an *insured employee* 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 financially dependent on the *insured employee*, *domestic partner* or *spouse*, and (iii) incapable of self-sustaining employment due to a physical handicap or mental retardation. A physician must certify this disability in writing. 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 and disability, but not more often than once each year. This exception will last until the *child* is no longer handicapped or dependent on the *employee*, *domestic partner* or *spouse* for financial support. A *child* is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

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

## BENEFITS AFTER INSURANCE ENDS

If a person's insurance ends, benefits for the dental services listed below will be paid if such services are completed within 31 days of the date insurance ends. Dental benefits may be paid for:

- an appliance, or modification of it, for which the impression was taken while the person was insured under this plan,
- a crown, bridge, inlay or onlay, for which the tooth was prepared while the person was insured under this plan, and
- root canal treatment, if the pulp chamber is opened while the person was insured under this plan.

## 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.

**If a *participating dentist* provides services or supplies, any billed amount above *covered dental expense* will be a savings to the *insured person*. *Participating dentists* have agreed to accept the *dental negotiated rate* as payment in full. *Non-participating dentists* have no such policy with UNICARE, therefore, they will bill you for any amounts over *covered dental expense*.**

## 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

#### Calendar Year Deductibles:

1. **Insured Person Deductible.** The *insured person* deductible is the amount of charges you must pay for any non-orthodontic *covered dental expense* incurred before any dental benefits are available to you under this *plan*. The *insured person* deductible will apply to each *insured person* for each *calendar year* before benefits become payable.  
The amount of the *insured person* deductible is specified in the SUMMARY OF BENEFITS. Only charges that are considered *covered dental expense* will count toward satisfying the *insured person* deductible.
2. **Family Deductible.** If enrolled members of a family pay *insured person* deductible amounts in a *calendar year* equal to 3 (three) times the *insured person* deductible amount shown in the SUMMARY OF BENEFITS, then the Dental Deductible for all *family members* is considered to have been met. No further 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.

## 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, except that for:
  - a. Dentures and other similar appliances: all expenses are incurred on the date the master impression is made.
  - b. Fixed bridges, crowns, inlays or onlays: all expenses are incurred on the date a tooth is first prepared.
  - c. Root canal therapy: all expenses are incurred on the later of the dates that the pulp chamber is opened or a canal is explored to the apex.
  - d. Periodontal surgery: all expenses are incurred on the date that the surgery is actually performed.
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*.

## BENEFIT WAITING PERIODS

An *insured employee* must be enrolled for one year (12 months) under this *plan* before becoming eligible for benefits under Category III-Major services. During the period of time the *insured employee* is subject to the *benefit waiting period*, any *insured family members* will also be subject to the same *benefit waiting period*.

**THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR THOSE SERVICES THAT WE DETERMINE TO BE “COVERED SERVICES”. THE FACT THAT YOUR DENTIST PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS A COVERED SERVICE OR THAT THE SERVICE IS A COVERED DENTAL EXPENSE.**

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 PARTY section.

## PRE-TREATMENT REVIEW

If your *dentist* anticipates the expense for any course of treatment to exceed \$300, your *dentist* may prepare a request for a pre-treatment benefit estimation, and submit the information to us before any treatment begins. We will review this request and send a copy of our response to you and your *dentist*.

If the course of treatment is not reviewed before treatment is received, it will be reviewed when the claim is submitted to us for payment.

## 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.

### CATEGORY I – PREVENTIVE & DIAGNOSTIC DENTAL SERVICES (NON-ORTHODONTIC)

CDT Code	Dental Service
	<b><i>Clinical oral evaluations</i></b>
D120	periodic oral evaluation
D140	limited oral evaluation
D150	comprehensive oral evaluation
	<i>One examination is allowed in any six (6) consecutive month period.</i>
	<b><i>Radiographs</i></b>
D210	intraoral - complete series (including bitewings)
D220	intraoral, periapical, first film
D230	intraoral, periapical, each additional film
D240	intraoral, occlusal film
D270	bitewings – single film
D272	bitewings – two films
D274	bitewings - four films
D330	panoramic film
	<ul style="list-style-type: none"><li>• <i>Bite wing x-rays are limited to four (4) films in any twelve (12) consecutive month period.</i></li><li>• <i>Intraoral complete series (including bitewings), or Panorex, are limited to once every five (5) years for those insureds age twelve and over.</i></li><li>• <i>Other intraoral x-rays will be covered to a maximum of four (4) periapical and two (2) occlusal every twelve (12) months.</i></li></ul>
	<b><i>Dental prophylaxis</i></b>
D1110	prophylaxis – adult
D1120	prophylaxis – child to age 16
	<i>One prophylaxis or one periodontal maintenance procedure is allowed once every six (6) consecutive month period.</i>
	<b><i>Topical fluoride treatment</i></b>
D1201	topical application of fluoride including prophylaxis - child to age 16
D1203	topical application of fluoride excluding prophylaxis - child to age 16
	<i>Fluoride treatments are limited to once every six (6) months.</i>
	<b><i>Other preventive services</i></b>
D1351	sealant -per tooth – child up to age 16
	<i>Sealants (one application) will be allowed in permanent first and second molars.</i>

## CATEGORY II - BASIC DENTAL SERVICES (NON-ORTHODONTIC)

CDT Code	Dental Service
	<b>Space maintenance</b>
D1510	space maintainer - fixed – unilateral
D1515	space maintainer - fixed – bilateral
D1520	space maintainer - removable – unilateral
D1525	space maintainer - removable – bilateral
D1550	recementation of space maintainer
	<i>Allowance for space maintainers includes initial appliance only and all adjustments in first six (6) months. Coverage is for dependent children to age 16.</i>
	<b>Restorative (also see Major Services)</b> Multiple restorations on one surface will be considered one restoration. Subsequent restorative services performed on same tooth and surface will be limited to the latter procedure.
	<b>Amalgam restorations</b>
D2140	amalgam - one surface
D2150	amalgam – two surfaces
D2160	amalgam – three surfaces
D2161	amalgam – four or more surfaces
	<b>Resin-based composite restorations</b>
D2330	resin - one surface, anterior
D2331	resin – two surfaces, anterior
D2332	resin – three surfaces, anterior
D2335	resin - four or more surfaces, anterior
D2390	resin-based composite crown, anterior
D2391	resin – one surface, posterior
D2392	resin – two surfaces, posterior
D2393	resin – three surfaces, posterior
D2394	resin – four or more surfaces, posterior
	<i>Benefits for composite resin restorations on posterior teeth and anterior primary teeth will be based on corresponding amalgam restoration.</i>
	<b>Oral Surgery</b> Allowance includes routine x-rays, treatment plan, local anesthesia, and post-surgical care.
	<b>Extractions</b>
D7111	extract coronal remnants- deciduous tooth
D7140	extract erupted tooth or exposed root
	<b>Surgical extractions</b>
D7210	surgical removal of erupted tooth
D7220	removal of impacted tooth - soft tissue
D7230	removal of impacted tooth - partially bony
D7240	removal of impacted tooth - completely bony
D7250	surgical removal of residual tooth roots
	<b>Alveoloplasty</b>
D7310	alveoloplasty with extractions - per quadrant
D7311	alveoloplasty with extractions – one to three teeth or tooth spaces, per quadrant
D7320	alveoloplasty without extractions - per quadrant
D7321	alveoloplasty without extractions – one to three teeth or tooth spaces, per quadrant
	<b>Surgical incision</b>
D7510	incision and drainage of abscess – intraoral soft tissue
D7511	incision and drainage of abscess – intraoral soft tissue, complicated
	<b>Other repair procedures</b>
D7960	frenulectomy – separate procedure
D7963	frenuloplasty
D7970	excision of hyperplastic tissue – per arch

## CATEGORY II - BASIC DENTAL SERVICES (NON-ORTHODONTIC) (continued)

CDT Code	Dental Service
	<b>Adjunctive General Services</b>
	<b>Unclassified treatment</b>
D9110	emergency palliative treatment
	<b>Anesthesia</b>
D9220	general anesthesia – first 30 minutes
D9221	general anesthesia – each additional 15 minutes
	<i>General anesthesia is allowed only when used in conjunction with covered oral surgical procedures.</i>
	<b>Professional consultations</b>
D9310	consultation (diagnostic service provided by dentist other than practitioner providing treatment)
	<i>Professional consultations limited to two (2) visits in any twelve (12) consecutive month period.</i>
	<b>Professional visits</b>
D9430	office visit for observation (during regular office hours) – no other services performed
D9440	office visit - after regularly scheduled hours

## CATEGORY III - MAJOR DENTAL SERVICES (NON-ORTHODONTIC)

CDT Code	Dental Service
	<b>Restorative (also see Basic Services)</b> Cast restoration and crowns covered only when tooth cannot be restored with routine filling material. Must be five (5) years old for replacement. Deciduous teeth limited to stainless steel. Benefits for noble and high noble metal are based on the corresponding porcelain or base metal crown, pontic, inlay, or onlay.
	<b>Inlay/onlay restorations</b>
D2510	inlay - metallic - one surface
D2520	inlay - metallic – two surfaces
D2530	inlay - metallic – three surfaces
D2542	onlay - metallic – two surfaces
D2543	onlay - metallic – three surfaces
D2544	onlay - metallic - four surfaces
D2610	inlay - porcelain/ceramic, one surface
D2620	inlay - porcelain/ceramic, two surfaces
D2630	inlay - porcelain/ceramic, three or more surfaces
D2642	onlay - porcelain/ceramic, two surfaces
D2643	onlay - porcelain/ceramic, three surfaces
D2644	onlay - porcelain/ceramic, four or more surfaces
D2650	inlay - resin-based composite, one surface
D2651	inlay - resin-based composite, two surfaces
D2652	inlay – resin-based composite, three or more surfaces
D2662	onlay – resin-based composite, two surfaces
D2663	onlay – resin-based composite, three surfaces
D2664	onlay – resin-based composite, four or more surfaces
	<b>Crowns</b>
D2710	crown – resin-based composite (indirect)
D2712	crown – ¾ resin-based composite (indirect)
D2720	crown – resin with high noble metal
D2721	crown – resin with predominantly base metal
D2722	crown – resin with noble metal
D2740	crown - porcelain/ceramic substrate
D2750	crown - porcelain fused to high noble metal
D2751	crown - porcelain fused to predominantly base metal
D2752	crown - porcelain fused to noble metal
D2780	crown - ¾ cast high noble metal

**CATEGORY III - MAJOR DENTAL SERVICES (NON-ORTHODONTIC) (continued)**

<b>CDT Code</b>	<b>Dental Service</b>
D2781	crown - ¾ cast predominantly base metal
D2782	crown - ¾ cast noble metal
D2783	crown - ¾ porcelain/ceramic substrate
D2790	crown - full cast high noble metal
D2791	crown - full cast predominantly base metal
D2792	crown - full cast base metal
D2794	crown - titanium
	<b>Other restorative services</b>
D2910	recement inlay, onlay or partial coverage restoration
D2915	recement cast or prefabricated post and core
D2920	recement crown
D2930	stainless steel crown - primary tooth
D2934	prefabricated esthetic coated stainless steel crown – primary tooth
D2940	sedative filling
D2950	core buildup, including pins
D2951	pin retention - per tooth
D2952	cast post and core in addition to crown
D2953	each additional cast post, same tooth
D2954	prefab post and core in addition to crown
D2955	post removal
D2957	each additional prefabricated post, same tooth
D2971	additional procedures to construct new crown under existing partial denture framework
D2975	coping
D2980	crown repair
	<i>Post and core limited to endodontically treated teeth.</i>
	<b>Endodontics</b> Allowance includes routine x-rays and cultures, but excludes final restoration.
	<b>Pulp capping</b>
D3110	pulp cap direct
D3120	pulp cap indirect
	<b>Pulpotomy</b>
D3220	therapeutic pulpotomy
D3221	pulpal debridement
	<b>Root canal therapy</b>
D3310	root canal - anterior
D3320	root canal - bicuspid
D3330	root canal - molar
D3346	retreatment root canal - anterior
D3347	retreatment root canal - bicuspid
D3348	retreatment root canal - molar
	<b>Apicoectomy/Periradicular services</b>
D3410	apicoectomy - anterior
D3421	apicoectomy - bicuspid (first root)
D3425	apicoectomy - molar (first root)
D3426	apicoectomy - each additional root
D3430	retrograde filling – per root
	<b>Periodontics</b> Allowance includes treatment plan, local anesthesia, and post-surgical care.
	<b>Surgical services</b>
D4210	gingivectomy/gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant
D4211	gingivectomy/gingivoplasty – one to three contiguous teeth or bounded teeth spaces, per quadrant
	<i>Limited to once every thirty-six (36) months.</i>

**CATEGORY III - MAJOR DENTAL SERVICES (NON-ORTHODONTIC) (continued)**

<b>CDT Code</b>	<b>Dental Service</b>
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces, per quadrant
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces, per quadrant
D4245	apically positioned flap <i>Limited to once every thirty-six (36) months.</i>
D4260	osseous surgery – four or more contiguous teeth or bounded teeth spaces, per quadrant
D4261	osseous surgery – one to three contiguous teeth or bounded teeth spaces, per quadrant <i>Limited to once every thirty-six (36) months and applied to other perio surgical procedures performed in the same area in the same 36-month period.</i>
<b>Non-surgical periodontal services</b>	
D4341	periodontal scaling and root planing – four or more teeth, per quadrant
D4342	periodontal scaling and root planing – one to three teeth, per quadrant <i>Limited to four (4) quadrants in any twenty-four (24) consecutive month period.</i>
D4355	full mouth debridement to enable comprehensive periodontal evaluation & diagnosis. <i>Limited to once in any twenty-four (24) consecutive month period.</i>
D4381	localized delivery of antimicrobial agent, per tooth
<b>Other periodontal services</b>	
D4910	periodontal maintenance <i>One prophylaxis or one perio maintenance procedure is allowed every six (6) consecutive months.</i>
<b>Prosthodontics</b> Allowance includes all adjustments in first six (6) months after initial placement of denture. Includes base, clasps, rests, and teeth.	
<b>Prosthodontics, Removable</b>	
<b>Complete dentures</b>	
D5110	complete upper
D5120	complete lower
<b>Partial dentures</b>	
D5211	upper partial - resin base
D5212	lower partial - resin base
D5213	upper partial - cast metal framework with resin denture base
D5214	lower partial - cast metal framework with resin denture base
D5225	upper partial – flexible base
D5226	lower partial – flexible base
D5281	unilateral partial - removable
<b>Adjustments to dentures</b>	
D5410	adjust complete upper denture
D5411	adjust complete lower denture
D5421	adjust partial upper denture
D5422	adjust partial lower denture <i>Denture adjustments covered only after six (6) months from time of initial denture placement.</i>

**CATEGORY III - MAJOR DENTAL SERVICES (NON-ORTHODONTIC) (continued)**

CDT Code	Dental Service
	<b>Repairs to complete dentures</b>
D5510	repair broken complete denture base
D5520	replace missing or broken teeth - each tooth
	<b>Repairs to partial dentures</b>
D5610	repair resin denture base
D5620	repair cast framework
D5630	repair or replace broken clasp
D5640	replace broken teeth - per tooth
D5650	add tooth to existing partial denture
D5660	add clasp to existing partial denture
D5670	replace all teeth and acrylic on cast metal framework, upper
D5671	replace all teeth and acrylic on cast metal framework, lower
	<i>Denture repairs covered only after twelve (12) months from time of initial denture placement.</i>
	<b>Denture reline procedures</b>
D5730	reline complete upper denture (chairside)
D5731	reline complete lower denture (chairside)
D5740	reline partial upper denture (chairside)
D5741	reline partial lower denture (chairside)
D5750	reline complete upper denture (lab)
D5751	reline complete lower denture (lab)
D5760	reline partial upper denture (lab)
D5761	reline partial lower denture (lab)
	<i>Relines limited to once per denture in any twenty-four (24) consecutive month period. Must be more than twelve (12) months from time of initial denture placement.</i>
	<b>Interim prosthesis</b>
D5820	interim partial denture - upper
D5821	interim partial denture - lower
	<i>Coverage for interim partial dentures is limited to anterior teeth.</i>
	<b>Other removable prosthetic services</b>
D5850	tissue conditioning – upper
D5851	tissue conditioning – lower
	<i>Limited to two (2) treatments per arch in any twelve (12) consecutive month period.</i>
	<b>Prosthodontics, Fixed</b> Coverage for bridgework is limited to insureds age 16 and over. Benefits for noble and high noble metal are based on the corresponding porcelain or base metal crown, pontic, inlay, or onlay. Must be five (5) years old for replacement.
	<b>Fixed partial denture pontics</b>
D6205	pontic – indirect resin-based composite
D6210	pontic – cast high noble metal
D6211	pontic – cast metal
D6212	pontic – cast noble metal
D6214	pontic - titanium
D6240	pontic – porcelain fused to high noble metal
D6241	pontic – porcelain fused to predominantly base metal
D6242	pontic – porcelain fused to noble metal
D6245	pontic – porcelain/ceramic
D6250	pontic – resin with high noble metal
D6251	pontic – resin with predominantly base metal
D6252	pontic – resin with noble metal
	<b>Fixed partial denture retainers – inlays/onlays</b>
D6545	retainer – cast metal for resin bonded fixed prosthesis
D6548	retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6600	inlay – porcelain/ceramic, two surfaces

**CATEGORY III - MAJOR DENTAL SERVICES (NON-ORTHODONTIC) (continued)**

<b>CDT Code</b>	<b>Dental Service</b>
D6601	inlay – porcelain/ceramic, three or more surfaces
D6602	inlay – cast high noble metal, two surfaces
D6603	inlay – cast high noble metal, three or more surfaces
D6604	inlay – cast predominantly base metal, two surfaces
D6605	inlay – cast predominantly base metal, three or more surfaces
D6606	inlay – cast noble metal, two surfaces
D6607	inlay – cast noble metal, three or more surfaces
D6608	onlay – porcelain/ceramic, two surfaces
D6609	onlay – porcelain/ceramic, three or more surfaces
D6610	onlay – cast high noble metal, two surfaces
D6611	onlay – cast high noble metal, three or more surfaces
D6612	onlay – cast predominantly base metal, two surfaces
D6613	onlay – cast predominantly base metal, three or more surfaces
D6614	onlay – cast noble metal, two surfaces
D6615	onlay – cast noble metal, three or more surfaces
D6624	inlay – titanium
D6634	onlay – titanium
	<b><i>Fixed partial denture retainers – crowns</i></b>
D6710	crown – indirect resin-based composite
D6720	crown – resin with high noble metal
D6721	crown – resin with predominantly base metal
D6722	crown – resin with noble metal
D6740	crown – porcelain/ceramic
D6750	crown – porcelain fused to high noble metal
D6751	crown – porcelain fused to predominantly base metal
D6752	crown – porcelain with noble metal
D6780	crown – ¾ cast high noble metal
D6781	crown – ¾ cast base metal
D6782	crown – ¾ cast noble metal
D6783	crown – ¾ porcelain/ceramic
D6790	crown - full cast high noble metal
D6791	crown - full cast predominantly base metal
D6792	crown - full cast noble metal
D6794	crown - titanium
	<b><i>Other fixed partial denture services</i></b>
D6930	recement fixed partial denture
D6970	cast post and core in addition to fixed partial denture retainer
D6971	cast post as part of fixed partial denture retainer
D6972	prefab post and core in addition to fixed partial denture retainer
D6973	core buildup for retainer, including pins
D6975	coping - metal
D6976	each additional cast post, same tooth
D6977	each additional prefabricated post, same tooth
D6980	fixed partial denture repair

## 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.)

**Duplicate Services or Supplies.** Any covered services or supplies, or any services or supplies for which benefits would be provided, under any other insurance policy, health care service plan, or similar arrangement which the *group* sponsors.

**Services Provided Before or After the Term of This Coverage.** Services received before your *effective date*, except as stated under DENTAL CARE THAT IS NOT COVERED. Services received after your coverage ends, except as specifically stated under BENEFITS AFTER INSURANCE ENDS.

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

**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.

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

**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.

**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, erosion, or bruxism
- Realignment of teeth
- Gnathological recording
- Occlusal equilibration (but not excluding such treatment needed to treat periodontal disease)
- Periodontal splinting
- Treatment related to temporomandibular joint (jaw joint) disturbances and/or hormonal imbalance.
- Nightguards, harmful habit and thumbsucking devices

**Prosthetic Replacements.** Replacement of fixed or removable prosthesis, 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.

**Prosthetics for Teeth Extracted Prior to Coverage.** Initial placement of prosthetics if teeth being replaced were missing before the *insured person* was covered by this *Plan*.

**Crown, Inlay, Onlay Replacements.** Replacement of crowns and cast restorations, if replacement occurs within five years of the original placement.

**Lost or Stolen Dentures or Appliances.** Replacement of existing full or partial dentures or prosthetic appliances which have been lost or stolen.

**Making a spare appliance or prosthetic device.**

**Cosmetic Dentistry.** Any services performed for cosmetic purposes, including, but not limited to facings on crowns or pontics posterior to the second bicuspid.

**Nitrous oxide.** Charges for nitrous oxide, Novocain, Xylocaine or any similar local anesthetic when the charge is made separately from a *covered dental expense*.

**Personalization.** Personalization of dentures or teeth, or precision attachments.

**Oral surgery** for or on:

- disturbances of the temporomandibular joint;
- fractures of the jaw;
- resectioning of the bone;
- repositioning of the teeth or bone implantation, re-implantation or transplantation, or
- salivary gland, duct or sinus.

**Congenital or developmental malformations.** Treatment of congenital or developmental malformations including but not limited to:

- cleft palate;
- maxillary and mandibular malformations
- enamel hypoplasia; or
- fluorosis

**Treatment, services or supplies received while hospitalized as an inpatient or on an outpatient basis.**

**Bonding or grafting.** Procedures related to bonding or grafting.

**Overdentures.**

**Oral hygiene, plaque control, diet instruction.**

**Orthodontic treatment, unless orthodontic rider is attached.**

**Services not specifically listed under DENTAL CARE THAT IS COVERED.**

## REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a third party may be liable or legally responsible by reason of negligence, and intentional act, or the breach of a legal obligation of such third party for an injury, disease or other condition for which an Insured receives *covered services*. In that event, any benefits we pay under this *plan* for such *covered dental expense* will be subject to the following:

- We will automatically have a lien upon any amount *you* receive from the third party, the third party's insurer, or guarantor by judgment, award, settlement or otherwise. Our lien will be in the amount of benefits we pay under this Certificate for treatment of the illness, disease, injury or condition for which the third party is liable. Our lien will not exceed the amount we actually paid for those services if we paid the provider other than on a capitated basis. If we paid the provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they are rendered. In addition, if *you* engaged an attorney to gain *your* recovery from the third party, our lien shall not be for a sum in excess of one-third of the monies due *you* under any final judgment, compromise, or settlement agreement. If *you* did not engage an attorney to gain *your* recovery from the third party, our lien shall not be for a sum in excess of one-half of the monies due *you* under any final judgment, compromise, or settlement agreement. Where a final judgment includes a special finding by a judge, jury or arbitrator that *you* were partially at fault, our lien shall be reduced by the same comparative fault percentage by which *your* recovery was reduced. Our lien is subject to a pro rata reduction commensurate with *your* reasonable attorney's fees and costs in accordance with the common fund doctrine.
- *You* agree to advise us, in writing of *your* claim against a third party within sixty (60) days of making such claim, and that *you* will take such action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our lien rights. *You* agree not to take any action that may prejudice our rights or interests under this *plan*. *You* agree also that failing to give us such notice, or failing to cooperate with us, or taking action that prejudices our rights will be a material breach of this *plan*. In the event of such material breach, *you* will be personally responsible and liable for reimbursing to us the amount of benefits we paid.
- We will be entitled to collect on our lien even if the amount recovered by or for the *insured employee or insured family member* (or his or her 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 suffered by the *insured employee or insured family member*.

## 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 amount which we would determine to be eligible expense, if you were covered under This Plan only.

**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 trusted 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 employee* 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.

## CONTINUATION OF COVERAGE – CAL-COBRA

If the *group* is an employer with between two (2) and nineteen (19) full-time, permanent, active employees on a typical business day, *you* may be entitled, in accordance with these provisions, to continue for a limited period of time coverage that would otherwise end. In order to continue coverage, *you* must qualify as described below, and *you* and the *group* must also satisfy the requirements set out below.

### DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appears in these provisions, the first letter of each word will appear in capital letters. 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 Cal-COBRA Continuation" provisions below.

**Qualified Beneficiary** means: (a) a person enrolled for this Cal-COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this certificate as either an *insured employee* or *insured family member*, (b) a *child* who is born to or placed for adoption with the *insured employee* during the Cal-COBRA continuation period, or (c) a *child* for whom the *insured employee* or *spouse* has been appointed permanent legal guardian by final court decree or order during the Cal-COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *insured family members* acquired during the Cal-COBRA continuation period, with the exception of newborns, adoptees, and children of permanent legal guardians as specified above.

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

**A. For Insured Employees And Insured Family Members:**

1. The *insured employee's* termination of employment, for any reason other than gross misconduct; or
2. A reduction in the *insured employee's* work hours.

**B. For Insured Family Members:**

1. The death of the *insured employee*;
2. The *spouse's* divorce or legal separation from the *insured employee*;
3. The end of a *child's* status as a dependent *child*, as defined by the *certificate*;
4. The *insured employee's* entitlement to Medicare; or
5. The loss of eligible status by an enrolled *family member*.

## ELIGIBILITY FOR CAL-COBRA CONTINUATION

An *insured employee* or *insured family member* may choose to continue coverage under the certificate if his or her coverage would otherwise end due to a Qualifying Event.

**Exception:** An *Insured employee* or *insured family member* is not entitled to continue coverage if, at any time of the Qualifying Event: (1) the *insured employee* or *insured family member* is entitled to Medicare; (2) the *insured employee* or *insured family member* is 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 employee* or *insured family member*; (3) UNICARE fails to receive timely notice of the Qualifying Event or election, as set out below, of a Cal-COBRA continuation, or (4) the *insured employee* or *insured family member* fails to submit the required premium as set out below. If one *insured employee* or *insured family member* is unable to continue coverage for these reasons, the *insured employee* or other entitled *insured family members* may still choose to continue their coverage.

## TERMS OF CAL-COBRA CONTINUATION

1. For Qualifying Event A., above, the *group* must notify the *insured employee* and UNICARE Dental Services within 31 days of the Qualifying Event of the right to continue coverage. UNICARE Dental Services in turn must, within 14 days, give you official notice of the Cal-COBRA continuation right.
2. You must inform UNICARE within 60 days of the Qualifying Event B., above, if you wish to continue coverage. UNICARE in turn must within 14 days give you official notice of the Cal-COBRA continuation right.

If you choose to continue coverage, you must notify UNICARE within 60 days of the date you receive notice of your Cal-COBRA continuation right. The Cal-COBRA continuation coverage may be chosen for the *insured employee* or *insured family members* within a covered family, or only for selected *insured family members*.

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

The initial premium must be delivered to us within 45 days after you elect Cal-COBRA continuation coverage.

An election of continuation coverage must be in writing and delivered to us by first class mail or other reliable means of delivery, including personal delivery, express mail or private courier company. The initial premium must be delivered to us at UNICARE Dental Services, PO Box 5347, Oxnard, CA 93031 by certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company, and must be in an amount sufficient to pay all premiums due. **A failure to properly give notice of an election of continuation coverage or a failure to properly and timely pay premiums due will disqualify you from continuing coverage.**

**Additional Insured Family Members.** A *child* acquired during the Cal-COBRA continuation period is eligible to be enrolled as an *insured family member*. The standard enrollment provisions of the certificate apply to enrollees during the Cal-COBRA continuation period. An *insured family member* acquired and enrolled after the effective date of continuation coverage resulting from the original Qualifying Event is not eligible for a separate continuation if a subsequent Qualifying Event results in the person's loss of coverage.

**Cost of Coverage.** The *group* may require that you pay the entire cost of your Cal-COBRA continuation coverage. This cost, called the "premium," must be remitted to UNICARE each month during the Cal-COBRA continuation period and shall be 110% of the rate applicable to an *insured employee* for whom a Qualifying Event has not occurred. **We must receive proper and timely payment of the premium each month from you in order to maintain the coverage in force.**

Besides applying to the *insured employee*, the *insured employee's* rate also applies to:

1. A *spouse* whose Cal-COBRA continuation began due to divorce, separation or death of the *insured employee*;
2. A *child* if neither the *insured employee* nor the *spouse* has enrolled for this Cal-COBRA continuation coverage (if more than one *child* is so enrolled, the premium will be based on the two-party or three-party rate depending on the number of children enrolled); and
3. A *child* whose Cal-COBRA continuation began due to the person no longer meeting the *child* definition.

**Subsequent Qualifying Events.** Once covered under the Cal-COBRA continuation, it is possible for a second Qualifying Event to occur. If that happens, an *insured employee* or *insured family member* who is a Qualified Beneficiary may be entitled to an extended Cal-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 Cal-COBRA continuation due to termination of the *insured employee's* employment, and enrolled for this Cal-COBRA continuation as a Qualified Beneficiary. If, during the Cal-COBRA continuation period, the *child* reaches the upper age limit of the *plan*, the *child* is eligible to remain covered for the balance of the continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

**When Cal-COBRA Continuation Begins.** When Cal-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 *insured family members* properly enrolled during the Cal-COBRA continuation, coverage begins according to the enrollment provisions of the Policy.

#### **When the Cal-COBRA Continuation Ends.**

**For insured employees or insured family members beginning Cal-COBRA continuation coverage effective on or after January 1, 2003, this continuation will end of the earliest of:**

1. The end of thirty-six (36) months from the Qualifying Event;\*
2. The date the Certificate terminates;
3. The end of the period for which premiums are last paid;
4. The date the *insured employee or insured family member* 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 employee or insured family member*, in which case this Cal-COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
5. The date the *insured employee or insured family member* becomes eligible for Medicare.

\*For an *insured employee or insured family member* whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation coverage under this *plan* ends because the *group* replaces our coverage with coverage from another company, the *group* must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

**For insured employee or insured family members beginning Cal-COBRA continuation coverage effective prior to January 1, 2003, this continuation will end of the earliest of:**

1. The end of eighteen (18) months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;\*  
**Note:** The eighteen (18) months may be extended for up to twenty-nine (29) months for Total Disability as determined by the Social Security Administration.
2. The end of thirty-six (36) months from the Qualifying Event, if the Qualifying Event was the death of the *insured employee*, divorce or legal separation, or the end of *insured family member* status;\*
3. For an *insured family member*, the end of thirty-six (36) months from the date the *insured employee* became entitled to Medicare, if the Qualifying Event was the *insured employee's* entitlement to Medicare;
4. The date the Certificate terminates;
5. The end of the period for which premiums are last paid;
6. The date the *insured employee or insured family member* becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the *insured employee or insured family member*, in which case this Cal-COBRA continuation will end at the end of the period for which the Preexisting Condition exclusion or limitation applied; or
7. The date the *insured employee or insured family member* becomes entitled to Medicare.

\*For an *insured employee or insured family member* whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation coverage under this *plan* ends because the *group* replaces our coverage with coverage from another company, the *group* must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

## **EXTENSION OF CONTINUATION DURING TOTAL DISABILITY**

**Note:** This section ("EXTENSION OF CONTINUATION DURING TOTAL DISABILITY) applies only to *insured employee or insured family members* who began Cal-COBRA continuation coverage effective prior to January 1, 2003.

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

**Eligibility for Extension.** To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *insured employee* or *insured family member* 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 employee* or *insured family member* must furnish UNICARE with proof of the Social Security Administration's determination of disability during the first 18 months of the Cal-COBRA continuation period and no later than 60 days after the date of the Social Security Administration's determination of such disability.

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

1. This charge shall be 150% of the applicable rate, depending upon the number of persons covered, and must be remitted to us by you each month during the period of extended continuation coverage.
2. The *group* may require that you pay the entire cost of the extended continuation coverage.
3. We must receive from you timely payment of the premium each month in order to maintain the extended continuation coverage in force.

**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 a period 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 the *insured employee* or *insured family member* 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 employee* or *insured family member*, in which case this Cal-COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
6. The date the *insured employee* or *insured family member* becomes entitled to Medicare.

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

## **POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER**

**Note:** This section ("POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER") applies **ONLY** to Insureds turning sixty (60) years of age prior to January 1, 2005.

Subject to payment of premiums stated in the *policy*, coverage under this *plan* may be continued for the *insured employee*, the *insured employee's spouse* and the *insured employee's former spouse* (if any) under Section 1373.62 of the Health and Safety Code and Section 10116.5 of the Insurance Code, in accordance with the following provisions. This continuation may be elected following the Cal-COBRA CONTINUATION OF COVERAGE shown above.

For the purpose of this section, "former *spouse*" means (a) an individual who is divorced from the *insured employee*; or (b) an individual who was married to the *insured employee* at the time of the *insured employee's* death.

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

- A. The *insured employee*, or the *Insured employee* on behalf of himself or herself and the *spouse*, was entitled to, and had elected to, continue coverage under Cal-COBRA as described in the preceding section;
- B. The *insured employee* or *spouse* has not elected to continue coverage under any other available continuation;
- C. The *insured employee* has worked for the employer for at least the prior five (5) years, and
- D. The *insured employee* is at least 60 years old on the date employment with the *group* 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 Cal-COBRA.

## TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE

**Note:** This section ("TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE") applies **ONLY** to Insureds turning sixty (60) years of age prior to January 1, 2005.

**Notice and Election.** UNICARE will notify you and your *spouse* or former *spouse* of the right to an extension in your continuation of coverage at least 90 days prior to the date continuation of coverage under Cal-COBRA is scheduled to end.

If you choose to continue coverage, you must notify UNICARE in writing within 30 days prior to the end of your Cal-COBRA continuation period.

If you fail to elect the extended Cal-COBRA continuation during the Post Cal-COBRA election period, you may not elect the Cal-COBRA continuation at a later date.

**Cost of Coverage.** The *group* may require that you pay the entire cost of your Cal-COBRA extended coverage. This cost, called the "premium," must be remitted to UNICARE each month during the Cal-COBRA extended continuation period and shall be 110% of the rate applicable to an *insured employee* for whom a Qualifying Event has not occurred. **We must receive proper and timely payment of the premium each month from you in order to maintain the coverage in force.**

Besides applying to the *insured employee*, the *insured employee's* rate also applies to a *spouse* or former *spouse* whose Cal-COBRA continuation began due to divorce, separation or death of the *insured employee*.

**When Post Cal-COBRA Continuation Ends.** This continuation will end on the earliest of:

1. The date the *policy* terminates;
2. The end of the period for which premiums are last paid;
3. The date the *insured employee* or *insured family member* 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 employee* or *insured family member*, in which case this Cal-COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
4. The date the *insured employee* or *insured family member* becomes eligible for Medicare.
5. For a *spouse* or former *spouse* of the *insured employee*, five (5) years from the date on which continuation coverage under Cal-COBRA was scheduled to end for the *insured employee*.
6. The date on which the employer or former employer terminates its *group policy* with the health care service *plan* and no longer provides coverage for any active employees through the *plan*.

## CONTINUATION OF COVERAGE - COBRA

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 employee* or *insured family member*; and (b) a *child* who is born to or placed for adoption with the *insured employee* during the COBRA continuation period. Qualified Beneficiary does not include 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. It does not include domestic partners 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*. These events are referred to throughout this section by number.

1. **For Insured Employees and Insured Family Members:**
  - a. The *employee's* termination of employment, for any reason other than gross misconduct; or
  - b. A reduction in the *employee's* work hours.
2. **For Retired Employees and their Insured Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided:
  - a. The *policy* expressly includes coverage for retirees; and
  - b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.
3. **For Insured Family Members:**
  - a. The death of the *insured employee*;
  - b. The *spouse's* divorce or legal separation from the *employee*;
  - c. The end of a *child's* status as a dependent *child*, as defined by the *policy*; or
  - d. The *employee's* entitlement to Medicare.

## ELIGIBILITY FOR COBRA CONTINUATION

An *insured employee* or *insured family member* 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 (we are not the administrator) will notify either the *insured employee* or *insured family member* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *group* or its administrator will notify the *employee* of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(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 3(b) or 3(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 employee*, the *employee's* premium rate will also apply to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee*;
2. A *child*, if neither the *employee* 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 employee'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 employee*, divorce or legal separation, or the end of dependent *child* status;\*

3. The end of 36 months from the date the *insured employee* became entitled to Medicare, if the Qualifying Event was the *employee'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 employee* will end 36 months from the date the *insured employee* 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. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

\*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*.

Subject to the *policy* remaining in effect, a retired *employee* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *family members* may continue coverage for 36 months after the *employee's* death. However, coverage could terminate prior to such time for either *employee* or *family member* in accordance with items 4, 5 or 6 above.

## 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 date of the Social Security Administration's determination of such disability.

**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. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

## POST-COBRA CONTINUATION FOR QUALIFYING INSURED PERSONS

**Note:** This section ("POST COBRA CONTINUATION FOR QUALIFYING INSURED PERSONS") applies ONLY to Insureds turning sixty (60) years of age 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 employee*, the *insured employee's spouse*, and the *insured employee's former spouse* (if any) under Sections 10116.5 and 11512.03 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 employee*; or (b) an individual who was married to the *insured employee* at the time of the *insured employee's* death.

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

1. The *employee*, or the *employee* 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 *employee* or *spouse* has not elected to continue coverage under any other available continuation;
3. The *employee* has worked for the employer for at least the prior five years; and
4. The *employee* 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 employer will notify the *insured employee* 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 *employee* and *spouse*, this continuation may be chosen for both, for the *employee* 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 the employer 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. Notice of continued coverage, along with the initial premium, must be delivered to us by the *group* within 45 days after you elect this continuation.

**Cost of Coverage.** This continuation is subject to payment of premiums to the employer at the time the *group* premium is due. The *group* may require that you pay the entire cost of your continuation coverage. The *group* is responsible to us for the timely payment of premium due for the continuation of your coverage under this *policy*. 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* continuing coverage alone will be considered to be an *employee*.

**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 post-COBRA, the *insured employee*, *spouse*, or former *spouse* first becomes covered under any group health plan not maintained by the employer;
4. The date, following the election of post-COBRA, the *employee*, *spouse*, or former *spouse* first becomes entitled to Medicare;
5. The date the *employee*, *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.

## 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*.

**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:** Either the *insured person* or provider of service must claim benefits by sending UNICARE properly completed claim forms itemizing the services or supplies received and the charges. These claim forms must be received by UNICARE within 12 months of the dates services or supplies for which claim is made are received. UNICARE will not be liable for the benefits of this *plan* if it does not receive completed claim forms within this time period. 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 and non-participating dentists* 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 and ERISA.** In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the *group* or to a person or entity, other than us, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health plan. The *group* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. 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*.

**Time Limit on Certain Defenses:** After you have been insured under this *policy* for two (2) consecutive years, we will not use any misstatements you may have made in your application for this *policy*, except any fraudulent misstatements, to either void this *policy* or to deny a claim for any *covered expense* incurred after the expiration of such two year period.

**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.

**Governing Law:** The laws of the State of California will be used to interpret any part of this *policy*.

## BINDING ARBITRATION

**Note:** If you are enrolled in a plan provided by your employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, or if your Employer does not provide a plan that is subject to ERISA, the following provisions apply:

Any dispute or claim arising out of the *policy*, or breach thereof, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court.

Any disputes regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The *insured person* and UNICARE agree to be bound by the arbitration provision and acknowledge that they are giving up their right to trial by court or jury.

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 arbitration is initiated by the Insured making written demand on UNICARE. 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 UNICARE, or by order of the court, if the Insured and UNICARE cannot agree.

The costs of this 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, UNICARE will assume all or a portion of the costs of the arbitration.

The *insured person* and UNICARE 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 waives any right to pursue, on a class basis, any such controversy or claim against UNICARE and UNICARE 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.

Please send all Binding Arbitration demands in writing to:

**UNICARE Life & Health Insurance Company**  
**PO Box 5347**  
**Oxnard, CA 93031**  
**800-995-4124**

## **EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)**

Under the federal Employee Retirement Income Security Act of 1974 (ERISA), Employer sponsored plans other than church or government Groups are subject to certain claim procedure rules. These rules, detailed in this Part, govern any claim or request for benefits, including Preservice Review or prior authorization for medical services. Preservice Review and prior authorization, when required by the plan, are considered to be part of a claim and are subject to ERISA procedure rules.

Any dispute regarding an adverse benefit decision may be submitted to voluntary binding arbitration only after the Insured has followed the ERISA appeal procedures. For an Insured enrolled in a plan subject to ERISA, any dispute which does not involve an adverse benefit decision is subject to binding arbitration (please see BINDING ARBITRATION).

This Certificate contains information on reporting claims, including the time limitations for submitting a claim. Claim forms may be obtained from the plan administrator or from UNICARE. If your Employer provides any plan that is subject to ERISA, ERISA applies some additional claim procedure rules, which are set forth throughout this Part. To the extent that ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in this Certificate.

**These ERISA rules apply only to adverse benefit decisions.** If you are enrolled in a plan provided by your Employer that is subject to ERISA, the rules outlined below will apply to adverse benefit decisions, but not to any other type of dispute you may have with UNICARE.

If you are enrolled in a plan provided by your Employer that is **not** subject to ERISA, the rules outlined below will **not** apply to you. For any grievance or dispute, please see BINDING ARBITRATION.

### **URGENT CARE (when care has not yet been received)**

Under ERISA, a claim involving urgent care is defined as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Insured. A preservice claim is any request for medical benefits that requires Preservice Review or prior authorization.

**Note:** All hours/days referred to are defined as calendar hours/days.

When you submit a request for benefits:

- UNICARE must notify you within seventy-two (72) hours of receipt of your request for benefits as to what we determine your benefits to be.
- If your request for benefits does not contain all the necessary information, UNICARE must notify you within twenty-four (24) hours of receipt of your request as to what information is needed to make a determination on your request.
- Any notice to you by UNICARE will be by telephone or in writing by facsimile or other rapid means.
- You have forty-eight (48) hours from receipt of this notice to provide to UNICARE the information needed to make a determination on your request for benefits. You may submit this information either by telephone or in writing by facsimile or other rapid means.

If your request for benefits is denied in whole or in part:

- UNICARE must provide written notice of the adverse benefit determination to you within seventy-two (72) hours after receiving all the information needed to make a determination on your request for benefits. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the adverse benefit determination was made.
- You have one hundred eighty (180) days from receipt of UNICARE's adverse benefit decision on your request for benefits to appeal UNICARE's decision. You may submit an appeal of the adverse benefit decision either by telephone or in writing by facsimile or other rapid means.
- Within seventy-two (72) hours of receipt of your appeal, UNICARE must notify you, either by telephone or in writing by facsimile or other rapid means, of its decision on your appeal.
- If your appeal does not result in a reversal of the adverse benefit decision, you may pursue additional voluntary appeals, including those outlined under BINDING ARBITRATION.

**NON-URGENT CARE – PRESERVICE (when care has not yet been received)**

**Note:** Any claim that does not meet the above-stated criteria for urgent care is considered to be a non-urgent care claim. A preservice claim is any request for medical benefits that requires Preservice Review or prior authorization.

**Note:** All days referred to are defined as calendar days.

When you submit a request for benefits:

- UNICARE must notify you within fifteen (15) days of receipt of your request for benefits as to what we determine your benefits to be. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial fifteen (15) day period of the circumstances requiring the extension of time and the date by which we expect to render a decision.
- In no case may UNICARE take more than thirty (30) days to make a determination on your request for benefits.
- If your request for benefits does not contain all the necessary information, UNICARE must notify you in writing within five (5) days of receipt of your request as to what information is needed to make a determination on your request.
- You have forty-five (45) days from receipt of this notice to provide to UNICARE the information needed to make a determination on your request for benefits.

If your request for benefits is denied in whole or in part:

- UNICARE must provide written notice of the adverse benefit decision to you within fifteen (15) days after receiving all the information needed to make a determination on your request for benefits. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the denial is based. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial 15-day period as to the circumstances requiring the extension of time and the date by which we expect to render a decision.
- You have one hundred eighty (180) days from receipt of UNICARE's adverse benefit decision on your request for benefits to appeal UNICARE's decision. You must submit your appeal in writing.
- Within thirty (30) days of receipt of your written appeal, UNICARE must notify you in writing of its decision on your appeal.
- If your appeal does not result in a reversal of the adverse benefit decision, you may pursue additional voluntary appeals, including those outlined under BINDING ARBITRATION.

**CONCURRENT CARE DECISIONS**

If, after approving a request for medical benefits in connection with your illness, injury, disease or other condition, UNICARE decides to reduce or end these benefits, in whole or in part:

- UNICARE must notify you sufficiently in advance of the reduction in, or end of, benefits to allow you the opportunity to appeal its decision before the reduction in, or end of, benefits occurs. This notice will explain the reason for reducing or ending your benefits and the plan provisions upon which the decision was made.

- To keep the benefits previously approved, you must successfully appeal UNICARE's decision to reduce or end those benefits. You must make your appeal to UNICARE at least twenty four (24) hours prior to the reduction in, or end of, benefits.
- If you appeal the decision to reduce or end your benefits less than twenty four (24) hours prior to the reduction in, or end of, benefits, your appeal will be treated as if you were appealing an urgent care adverse benefit decision (see the section entitled URGENT CARE, above).
- If UNICARE receives your appeal for benefits at least twenty four (24) hours prior to the reduction in, or end of, benefits, we must notify you of our decision regarding your appeal within twenty four (24) hours of receipt of the appeal. If UNICARE denies your appeal of the decision to reduce or end your benefits, in whole or in part, we must explain the reason for the adverse benefit decision and the plan provisions upon which the decision was based.
- You may further appeal the adverse benefit decision according to the rules for appeal of an urgent care adverse benefit decision (see URGENT CARE, above).

## **NON-URGENT CARE – POST SERVICE (after care has been received)**

**Note:** Under ERISA rules, a post-service claim is not considered to be an urgent or pre-service care claim.

**Note:** All days referred to are defined as calendar days.

### When you submit a claim:

- UNICARE must notify you in writing within thirty (30) days of receipt of your claim as to what we determine your benefits to be. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial thirty (30) day period as to the circumstances requiring the extension of time and the date by which we expect to render a decision.
- In no case may UNICARE take more than forty-five (45) days to make a determination on your claim.
- If your claim does not contain all the necessary information, UNICARE must notify you in writing within thirty (30) days of receipt of your claim as to what information is needed to make a determination on your claim.
- You have forty-five (45) days from receipt of this notice to provide to UNICARE the information needed to make a determination on your claim.

### If your claim is denied in whole or in part:

- UNICARE must provide written notice of the adverse benefit decision to you within thirty (30) days after receiving all the information needed to make a determination on your claim. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the denial decision is based.
- You have one hundred eighty (180) days from receipt of UNICARE's adverse benefit decision on your claim to appeal UNICARE's decision. You must submit your appeal in writing to UNICARE.
- Within thirty (30) days of receipt of your written appeal, UNICARE must notify you in writing of its decision on your appeal.
- If your appeal does not result in a reversal of the adverse benefit decision, you may pursue additional voluntary appeals, including those outlined under the section entitled BINDING ARBITRATION.

**Note:** You, your beneficiary, or a duly authorized representative may appeal any adverse benefit decision on a claim for benefits with UNICARE and request a review of the adverse benefit decision. In connection with such a request, documents pertinent to the administration of the plan may be reviewed free of charge, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

## **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.

**Benefit Waiting Period.** The required period of continuous coverage under this Plan, after the Effective Date of Coverage, that must be completed by an *insured person* before becoming eligible for benefits as specified in section entitled BENEFIT WAITING PERIOD.

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

**Covered Expense** is the expense the *insured person* incurs for *covered services* but in no event more than:

(1) for *covered services* provided by a *participating dentist*, the *covered expense* will not exceed the *dental negotiated rate*; and

(2) for *covered services* provided by a *non-participating dentist*, the *covered expense* is the lesser of the *dentist's* actual charge, or the amount UNICARE has set as reimbursement for that particular service. UNICARE will set the reimbursement amount at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region as follows: (1) we purchase dental claims data from an independent and reliable third party vendor who gathers such information as regular part of its business; (2) such data shows us on a national basis what the majority of dentists charge in a given area for various services; (3) we

will update this third party data for use as the basis of our reimbursement formula as we determine appropriate; and (4) we will use that data to determine allowances for services performed by *non-participating dentists* which we have determined reasonably reflects the common range of fees charged by a majority of *dentists* for a given service in a given geographic region.

**Covered Services** are *medically necessary* services or supplies which are listed in the benefit sections of this certificate, and for which you are, in accordance with the terms, conditions, limitations and exclusions of this certificate, entitled to receive benefits.

**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 Preferred 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 family member as outlined under HOW COVERAGE BEGINS AND ENDS.

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

**Experimental Procedures** are those that are not widely accepted as proven and effective procedures within the organized dental community.

**Full-time employee** meets the *plan's* eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.

**Group** refers to the business entity to which we have issued this *policy*.

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

**Insured person** is the *insured employee* 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 dental community.

**Late Entrant.** An *insured employee* or *insured family member* who becomes insured more than 31 days after eligibility, or becomes insured again after coverage ended due to voluntary disenrollment.

**Medically Necessary** are procedures, supplies, equipment or services that are considered to be:

- appropriate for the symptoms, diagnosis, or treatment of a dental condition, and
- provided for the diagnosis or direct care and treatment of the dental condition, and
- within the standards of good dental practice within the organized dental community, and
- not primarily for the convenience of the patient's *dentist* or another provider, and
- the most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular dental condition being treated than other possible alternatives; and
  - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

**Non-participating dentist** is a *dentist* which does NOT have a Preferred Provider Agreement with us at the time services are rendered.

**Participating dentist** is a *dentist* which has a Preferred Provider 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 certificate and in the amendments to this certificate, 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 certificate will be issued to the *group* for distribution to each *insured employee* affected by the change.

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

**Prior plan** is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* effective date; 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.

**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 employee* and *insured family members* who are enrolled for benefits under this *plan*.