CAHP Dental Trust

Preferred Provider Organization

Evidence of Coverage

Sponsored by

The California Association of Highway Patrolmen

Dental claims administered by

Anthem Blue Cross®

on behalf of

Anthem BC Life and Health Insurance Company

Revised January 1, 2015

IMPORTANT

No person has the right to receive any benefits of this Plan following termination of coverage, except as specifically provided under the TERMINATION AND RELATED PROVISIONS section in this Evidence of Coverage form.

Benefits of this Plan are available only for services and supplies furnished during the term the Plan is in effect and while the benefits you are claiming are actually covered by this Plan.

Reimbursement may be limited during the term of this Plan as specifically provided under the terms in this Evidence of Coverage form. Benefits may be modified or eliminated upon subsequent years' renewals of this Plan. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for service or supplies furnished on or after the effective date of modification. There is no vested right to receive the benefits of this Plan.

Please see inside back cover for important contact information for this plan.

CAHP DENTAL TRUST
Plan Year 2015

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CLAIMS

For dental claims submission or inquiries, benefit information, identification cards, or to obtain forms or finding a Participating Dentist, contact:

Anthem Blue Cross
Attn: CAHP Dental Claims Unit
PO Box 659444
San Antonio, TX 78265
1-800-627-0004
www.anthem.com/ca

GRIEVANCE/APPLEALS DEPARTMENT

Anthem Blue Cross
Grievance Department
PO Box 659471
San Antonio, TX 78265
1-800-627-0004

DIRECT PAYMENT OF PREMIUMS

If you are eligible to continue your group membership while off pay status, send your payment together with a completed FORM STD696 to:

CAHP Dental Trust
2030 V Street
Sacramento, CA 95818

CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

CalPERS
PO Box 942714
Sacramento, CA 94229-2714
1-888-225-7377
www.calpers.ca.gov

CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

California Department of Human Resources
1515 S. Street, North Building, Suite 400
Sacramento, CA 95811-7258
916-322-0300
www.calhr.ca.gov

HOW TO USE YOUR PLAN

INTRODUCTION

The CAHP Dental Trust (Trust) is a self-insured welfare trust that is sponsored by the California Association of Highway Patrolmen (CAHP).

The Trust offers comprehensive dental care coverage exclusively to members and Employees of the CAHP under a Participating Provider arrangement that is negotiated annually with Anthem Blue Cross Life and Health Insurance Company.

The Trust contracts directly with Anthem Blue Cross Life and Health Insurance Company, an affiliate of Anthem Blue Cross, as Claims Administrator of the dental program benefit offered herein. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. As used in this Evidence of Coverage, the term ”Anthem” shall be used for convenience to refer to both Anthem Blue Cross Life and Health Insurance Company and Anthem Blue Cross.

DENTAL BLUE

CAHP Dental Trust Plan offers the flexibility and freedom to select any Provider of choice. However, your dental benefits will vary depending on your choice of Providers. Savings are maximized when a Dentist who is a Dental Blue Participating Provider is chosen.

There are three Dental Blue PPO network choices: Dental Blue 100, Dental Blue 200, and Dental Blue 300. The Trust has chosen Dental Blue 200. The extensive network of Dental Blue 200 Participating Providers includes approximately fifty percent of all Dentists in private practice throughout California as well as Providers located outside of California. Dental Blue 200 Participating Providers have agreed to accept Negotiated Rate as payment in full for covered services. You will normally receive the greatest level of benefits when you seek treatment from a Participating Provider in the Dental Blue 200 network.

Dental Blue 300 Participating Providers have also agreed to provide covered services to you at a reduced rate. You are responsible to pay any difference between the Dental Blue 200 Negotiated Rate and the reduced rate for services of a Dental Blue 300 Participating Provider. This additional amount is called protected balance billing.

Please call Anthem customer service at **1-800-627-0004** or visit the web site at **www.anthem.com/ca** to obtain a listing of Participating Provider Dentists.

UTILIZING DENTAL BLUE PARTICIPATING PROVIDERS

The Dental Blue networks are subject to change. It is each Member’s responsibility to make sure that the Dentist he or she chooses or has been referred to is a Participating Provider, in case there have been any changes since the directory was published.

As a CAHP Dental Trust Plan Member, when you receive services from a Participating Provider, no claim forms need to be completed by you. Participating Providers have agreed to bill Anthem directly. The benefits of this Plan will be paid directly to Participating Providers.

To help ensure that the Participating Provider bills correctly:

- When you schedule an appointment, confirm with the Dentist that he or she is a Dental Blue Participating Provider.
- Present your CAHP Dental Trust identification card on the first visit to the Dentist.
- Ask your Dentist if he or she has on file an assignment of benefits for you (This assignment ensures that payment of benefits will be made directly to your Dentist).

If your Dentist requests that you pay for services at the time of your visit, remind them that as a Participating Provider, he or she should submit an itemized bill to Anthem for payment. A Participating Provider may, however, ask you to pay any applicable deductible and co-payment.

When you receive covered services from a Participating Provider, your co-payment will be a percentage of the Maximum Allowed Amount. The Maximum Allowed Amount is guaranteed to reduce your out-of-pocket costs for covered services and also saves the Trust fund valuable claims dollars, which helps to hold down the percentage of future premium increases. You may request a list of Participating Providers by calling Anthem at **1-800-627-0004** or visit the web site at **www.anthem.com/ca** to obtain a listing of Participating Providers.

When you receive services from a Non-Participating Provider, Anthem will determine the Maximum Allowed Amount, as stated under **GENERAL DEFINITIONS**. A Non-Participating Provider is not contracted to accept the Maximum Allowed Amount as payment in full. This may result in a higher out-of-pocket cost to you as well as increase the claims expense paid by the Trust fund.

HOW TO FILE A CLAIM

When you require dental care present your CAHP Dental Trust identification card to your Dentist.

Participating Providers will submit claims for service and be directly reimbursed, on behalf of the Trust, by Anthem.

Non-Participating Providers may require you to file claims for service.

NOTE: If the Plan is the secondary payer, a copy of the explanation of benefits from the primary carrier shall be required in order to process your claim.

SUBMISSION OF BILLS

Members filing claims for services received from Non-Participating Providers must submit itemized bills attached to claim forms to the following address:

Anthem
Attn: CAHP Dental Claims Unit
P.O. Box 659444
San Antonio, Texas 78265
1-800-627-0004

To obtain a dental claim form, call Anthem at the telephone number listed above or visit the web site at **www.anthem.com/ca**.

If you have questions regarding your claim, please contact Anthem at the address and telephone number listed above.

NOTE: The Trust is not liable for the benefits of this Plan if claims are not filed within the required time periods listed below:

- Fully completed dental claims must be submitted to Anthem within 90 days of the date services are received. If it is not reasonably possible to submit a claim within that time frame, an extension of up to 12 months will be allowed. Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; cancelled checks or receipts are not acceptable.

WHEN TRAVELING

Inside the United States: You must send a completed claim form and itemized bill to Anthem for services.

Outside the United States: Your Plan benefits are provided anywhere in the world. If you are in a foreign country, you may have to pay the bill and then be reimbursed. If you require dental care ask for an itemized bill, written in English.

QUESTIONS AND ADDITIONAL INFORMATION

Remember, it is your responsibility to stay informed about your dental benefits coverage.

For dental claims submission or status, benefit information, identification cards, or to obtain claim forms or a Directory of Participating Providers, contact:

Anthem Blue Cross
Attn: CAHP Dental Claims Unit
PO Box 659444
San Antonio, TX 78265
1-800-627-0004

Visit the web site at **www.anthem.com/ca** to obtain information on a Participating Provider and other valuable information about Anthem.

For information regarding eligibility or enrollment:

- Active Employees, contact your benefits clerk in your area office or CHP Personnel at (916) 843-3700.
- Annuitants, contact CalPERS Office of Employer and Member Health Services at P.O. Box 942714, Sacramento, CA 94229-2714 or call 1-888-225-7377.

DIRECT PAYMENT OF PREMIUMS

If you are eligible to continue your group membership while off pay status, send your payment together with a completed Form STD696 to:

CAHP Dental Trust
2030 V Street
Sacramento, CA 95818

DENTAL BENEFITS

Benefits will be paid for Covered Services incurred while covered under this Plan, subject to all terms, conditions, limitations and exclusions specified in this Evidence of Coverage Form.

HOW MAXIMUM ALLOWED AMOUNT IS DETERMINED

This section describes how the amount of reimbursement for covered services or supplies is determined. Reimbursement for dental services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the covered service or supply you receive.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement allowed for services and supplies:

- That meet the requirements to the extent such services and supplies are covered under your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable utilization review or other requirements set forth in your Plan.

Participating Providers have agreed not to charge you more than the Maximum Allowed Amount for the covered services you receive. When you choose a Participating Provider, you will not be responsible for any amount in excess of the Maximum Allowed Amount for covered services. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your deductible, or have a copay or coinsurance.

Your share of the cost of your dental care may be greater if you choose a Non-Participating Provider. You will be responsible for any billed charge which exceeds the Maximum Allowed Amount for covered services provided by a Non-Participating Provider.

Important: If you decide to receive dental services that are not covered under this Plan, a Participating Provider may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Plan, please call the customer service telephone number listed on your ID card. To fully understand your coverage under this Plan, please carefully review this Evidence of Coverage Form.

DENTAL CONDITIONS OF SERVICE

The following conditions of service must be met in order for the expense to be covered.

1. The Member must incur this expense while covered for dental benefits under this Plan. Expense is incurred on the date the Member receives the service or treatment for which the charge is made, except that for:
    a. dentures and other similar Prosthetic devices, all expenses are incurred on the date the final impression is made.
    b. fixed bridges, crowns, inlays or onlays, all expenses are incurred on the date the 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 Provider and must be for preventive care or for treatment of dental disease or injury.
3. The expense must be incurred for a dental service or supply that is included under **DENTAL BENEFITS**. Limits on Covered Services are included under specific benefits in **DENTAL BENEFIT MAXIMUMS**, **DENTAL PAYMENT RATES**, and **GENERAL EXCLUSIONS AND LIMITATIONS**.
4. The expense must not be for a dental service or supply listed under **GENERAL EXCLUSIONS AND LIMITATIONS**. If the service or supply is partially excluded, then only that portion which is not excluded will be covered.
5. The expense must not exceed any of the maximum benefits or limitations of this Plan.

DENTAL UTILIZATION REVIEW

Dental utilization review is designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. It is included in your Plan to encourage you to utilize your dental benefits in a cost-effective and clinically recognized manner. Your right to benefits for Covered Services provided under this Plan is subject to certain policies, guidelines and limitations, including, but not limited to, Anthem coverage guidelines, dental policy and utilization review features.

Dental utilization review is accomplished through pre-treatment review and retrospective review. Coverage guidelines under the Plan for pre-treatment review and retrospective review are intended to reflect the standards of care for dental practice and state-specific regulations. The purpose of dental coverage guidelines is to assist in the interpretation of medical necessity. In order to be expenses or services covered under this Plan, such expenses and services must meet the Medically Necessary requirements.

PRE-TREATMENT REVIEW

You may have a pre-treatment review done before you begin any course of treatment. Pre-treatment review is not a prior authorization for services but is a system that allows you and your Dentist to know, in advance, what the estimated benefits payable would be under your Plan for a proposed course of treatment.

The actual benefits you receive under the Plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

Under pre-treatment review, your Dentist prepares a request for a pre-treatment benefit estimation form and submits this form to Anthem before any treatment begins. The pre-treatment benefit estimation form should: (a) list the recommended dental services; and (b) show the charge for each dental service. Anthem will review this request and send a copy of estimated benefits to you and your Dentist. Anthem may request supporting pre-operative x-rays or other diagnostic records in connection with the pre-treatment review. A pre-treatment review is recommended if the proposed course of treatment is expected to involve charges of **$350 or more**.

Failure to obtain a Pre-Treatment Review will not necessarily result in denial of benefits. If the course of treatment is not reviewed before treatment is received, it will be reviewed when the claim is submitted for payment (retrospective review).

If you or your Dentist disagrees with the Pre-Treatment Review decision, you may request reconsideration by submitting additional documentation to Anthem.

You and your Dentist make the final decision on your treatment. However, the benefits provided under this Plan are based on the most cost-effective procedure and you will be responsible for any charges in excess of the Maximum Allowed Amount.

PRIOR CARRIER AUTHORIZATIONS

If you were previously covered under another dental plan and received a pre-treatment review, benefit authorization, or prior approval from the prior plan, such authorizations will not be honored by this Plan, except as outlined under **DENTAL CONDITIONS OF SERVICE**. You should request that your Dentist submit a Treatment Plan to Anthem before services are received or completed, if you began treatment before changing to this Plan. Incomplete services that were started before your Effective Date that would otherwise be eligible for benefits may not be covered under this Plan.

RETROSPECTIVE REVIEW

Retrospective review means a medical necessity review that is conducted after dental care services have been provided. A retrospective claim review includes, but is not limited to, an evaluation of reimbursement levels, accuracy of documentation, accuracy of coding and adjudication of payment.

Anthem provides a toll-free telephone number available during normal business hours to assist you or your Provider in obtaining information with respect to the utilization review process. This same number may be utilized after business hours to leave a message which will be responded to within two business days in non-emergent situations. This telephone number is listed on your identification card.

If you disagree with a utilization review decision and wish to file a Grievance or Appeal a decision previously made, you will find details on how to do this in the **GRIEVANCE/CLAIMS REVIEW PROCEDURE** section beginning on page 29 of this Evidence of Coverage. You may also contact customer service at **1-800-627-0004**.

The utilization review process is governed by laws and regulations and may be modified from time to time as those laws and regulations may require.

DENTAL DEDUCTIBLES

The Dental Deductible amounts are specified below under the **CALENDAR YEAR DENTAL DEDUCTIBLES** provision. Only charges that are considered Covered Services will count toward satisfying the Dental Deductibles.

The Deductibles are waived for diagnostic and preventive services.

Individual Deductible: Each Calendar Year, you will be responsible for satisfying the Individual Deductible before benefits under the Plan are paid. The Individual Deductible will apply to each Member for each Calendar Year before benefits become payable.

Family Deductible: If, during a Calendar Year, enrolled members of a family pay deductible expense equal to the Family Deductible amount shown below under the **CALENDAR YEAR DENTAL DEDUCTIBLES**

provision, then the Dental Deductible for all Members of that family is considered to have been met. No further Dental Deductible is required for the remainder of the Year.

Last Quarter Dental Deductible Carry-Over: Covered Services you incur during the last quarter of the year (October, November, and December) and applied toward the Dental Deductible for that Calendar Year will also be applied to your deductible for the next following year.

CALENDAR YEAR DENTAL DEDUCTIBLES*	
Individual Deductible	**$50**
Family Deductible	**$150**

***Exception:** The Calendar Year Dental Deductibles do not apply to Covered Services for diagnostic and preventive services.

DENTAL BENEFIT MAXIMUMS

Calendar Year Maximum: Your combined benefits, excluding orthodontics, are subject to the Calendar Year Maximum shown below. The Plan will not pay any benefit in excess of that amount for Covered Services incurred during a Calendar Year for each Member. Also, all payments are subject to any limitations specified in this Evidence of Coverage Form.

- Calendar Year Maximum (per Member) **$2,000**

Orthodontic Lifetime Maximum: Orthodontic benefits are subject to the Orthodontic Lifetime Maximum shown below. The Plan will not pay any orthodontic benefits in excess of that amount during a Member's lifetime. In addition, all payments are subject to any limitations specified in this Evidence of Coverage.

- Orthodontic Lifetime Maximum
  (one case during the lifetime of a Member) **$1,000**

HOW DENTAL BENEFITS ARE PAID

Please read the following information carefully so you will know how dental care will be reimbursed.

Participating Providers. A Participating Provider is a provider who is in the network for this Plan or who has a participation contract with Anthem. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for your Plan is the rate the provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your deductible, or have Coinsurance. You have an incentive under this Plan to seek treatment from a Dental Blue 100 or a Dental Blue 200 Participating Provider. If you choose to receive services from a Dental Blue 300 Participating Provider, you will incur additional charges over and above your Dental Deductible and Coinsurance amounts. These additional charges are the difference between the Dental Blue 200 and the Dental Blue 300 Participating Provider. This difference is called "protected balance billing."

Protected balance billing is a Plan feature that limits out-of-pocket expenses should you choose to receive Covered Services from a Dental Blue 300 Participating Provider.

If you receive Covered Services from a Dental Blue 300 Participating Provider, the Dentist can bill you for the difference between the Dental Blue 200 and Dental Blue 300 Maximum Allowed Amount.

Please refer to your identification card to verify that you are a member of Dental Blue 200. If you are uncertain which Participating Providers will provide you with the lowest out-of-pocket expense, please contact customer service at the toll-free number indicated on your identification card or visit online at www.anthem.com/ca.

Non-Participating Providers. Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are Non-Participating Providers. For Covered Services you receive from a Non-Participating Provider, the Maximum Allowed Amount for this Plan will be one of the following: The protected balance billing feature does **not** apply to services provided by Non-Participating Providers.

1. An amount based on Anthem's Non-Participating Provider fee schedule, which Anthem has established, and which may be modified from time to time, after considering some or all of the following: record fee data, reimbursement amounts accepted by like or similar providers contracted with Dental Blue 200, reimbursement amounts accepted by like or similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or
2. An amount based on information provided by a third party vendor, which reflects providers' charges for delivering care, or
3. An amount negotiated by Anthem or a third party vendor which has been agreed to by the provider; or
4. An amount equal to the total charges billed by the provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Non-Participating Provider's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Participating Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call customer services at **1-800-627-0004** for help in finding a Participating Provider or visit the website at **www.anthem.com/ca.**

Customer service is also available to assist you in determining this *plan's maximum allowed amount* for a particular service from a *non-participating provider.* In order for us to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out of pocket responsibility. Although customer service can assist you with this pre-service information, the final *maximum allowed amount* for your claim will be based on the actual claim submitted by the provider.

SUMMARY OF COSTS

If you receive treatment from a Dental Blue 100 or Dental Blue 200 Participating Provider:

- Payment rates will be based on the percentages listed under **DENTAL PAYMENT RATES**.
- You are responsible for any Coinsurance, dental deductibles, non-covered services, and any amounts over the dental benefit maximums as outlined in **DENTAL BENEFITS**.

If you receive treatment from a Dental Blue 300 Participating Provider:

- Payment rates will be based on the percentages listed under **DENTAL PAYMENT RATES**.
- You are responsible for any Coinsurance, dental deductibles, non-covered services, and any amounts over the dental benefit maximums as outlined in **DENTAL BENEFITS** *PLUS* any applicable protected balance billing amounts.

If you receive treatment from a Non-Participating Provider:

- Payment rates will be based on the percentages listed under **DENTAL PAYMENT RATES**.
- You are responsible for any Coinsurance, dental deductibles, non-covered services, and any amounts over the dental benefit maximums as outlined in **DENTAL BENEFITS**, *PLUS* any amount which exceeds Maximum Allowed Amount. The protected balance billing feature does not apply.

DENTAL PAYMENT RATES

After the Calendar Year Dental Deductible has been satisfied, the Plan will pay the percentage of Maximum Allowed Amount shown below for the type of services received, up to the Dental Benefit Maximums.

DIAGNOSTIC AND PREVENTIVE SERVICES

Two oral examinations per Calendar Year (office visits, emergency exams, consultations or any other type of exam shall be considered as an oral exam for the purpose of this limitation)	**100%**
Two Prophylaxis (teeth cleaning) per Calendar Year	**100%**
One Fluoride application per Calendar Year for Members under age 16	**100%**
Sealants for Members under age 16 (on permanent, cavity-free molars and/or bicuspids only, once in a 36 month period)	**100%**
Space maintainers	**100%**
Study Models/Casting (for orthodontic treatment only)	**100%**
Dental X-rays*	**100%**

*Note: Limited to complete series (full mouth x-ray) once every five years and bitewings (one set of up to four films) twice per Calendar Year. Complete series radiographs include bitewings and will count as one occurrence for that year. Nine or more radiographs in any combination of periapical, occlusal, and bitewing radiographs will be considered a complete series.

RESTORATIVE SERVICES

Composite and silver amalgam fillings	**90%**
Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or adjusting, relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months	**90%**
Gold Fillings	**80%**

ENDODONTIC SERVICES

Endodontic treatment including root canal therapy	**90%**

PERIODONTIC SERVICES

All periodontal treatment, including periodontal surgery, of diseased periodontal structures for periodontal and other diseases affecting such structures	**90%**

ORAL SURGERY

Extractions of teeth and minor oral surgery	**90%**
General anesthesia, when Medically Necessary and administered in connection with covered oral surgery	**90%**
Injection of antibiotic drugs	**90%**

EMERGENCY SERVICES

Emergency palliative treatment	**100%**

PROSTHETIC SERVICES (FIXED AND REMOVABLE)

Crowns	**80%**
Inlays	**80%**
Precision attachments for dentures	**80%**
Initial installation of fixed bridgework (including crowns and inlays to form abutments) to replace one or more natural teeth	**50%**
Replacement of an existing partial denture or fixed bridgework by a new fixed bridgework, or the addition of teeth to an existing fixed bridgework	**50%**
Initial installation of partial or full removable dentures (including adjustments for the six-month period following installation) to replace one or more natural teeth	**50%**
Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to an existing partial denture	**50%**
Bruxism Appliances, nightguard for grinding of teeth only	**50%**

ORTHODONTIC SERVICES

Up to 24 months active orthodontic treatment, limited to one course of treatment during a Member's lifetime	**50%**
All retainers and adjustments	**50%**

Note: If treatment began before enrolling under this Plan, you are eligible for orthodontic benefits for continued treatment once your coverage begins under this Plan.

PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be made under **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.)

Appliances: Athletic mouthpieces. TMJ Appliances or nightguard, except as stated under Prosthetic Services.

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

Cosmetic Dentistry: Any services performed for cosmetic purposes including, but not limited to, external bleaching, bleaching of non-vital discolored teeth, veneers, crowns on teeth not exhibiting pathology, and facings on crowns on posterior teeth, unless they are for correction of functional disorders or as a result of an Accidental Injury occurring while the Member was covered for dental benefits under this Plan. Composite filling and porcelain crowns on posterior teeth are considered cosmetic.

Crime: Conditions that result from a Member's commission of or attempt to commit an assault or felony. Services, treatments or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs.

Crown Replacements: Crowns, inlays, onlays cast restorations on the same tooth in excess of once every five years of the original placement.

Denture Repairs, Adjustments or Relines: Repairs, adjustments or relines of full or partial dentures or other prostheses are not covered for a period of six months from the initial placement if they were paid for under this Plan but not more than one relining or rebasing in any period of 36 consecutive months.

Duplicate Dentures or Appliances: Charges for any duplicate Prosthetic device or Appliance or a spare set of dentures or any other duplicate Appliance such as removable orthodontic retainer.

Excess Expense: Any amounts in excess of the Maximum Allowed Amount or the Dental Benefit Maximums.

Experimental or Investigative Procedures: Any procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation or which are not widely accepted as proven and effective procedures within the organized dental community.

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

Harmful Habit Appliances. Fixed and removable Appliances to inhibit thumb sucking.

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

Implants: Materials implanted into or on bone or soft tissue and all adjunctive services including, but not limited to, surgery, cleanings, and maintenance performed in conjunction with the placement or the removal of implants. However, if implants are provided in connection with a covered Prosthetic, the cost of a standard complete or partial denture, or a bridge, will be allowed toward the cost of the implants and the Prosthetic.

Lost or Stolen Dentures Or Appliances: Replacement of existing full or partial dentures or prosthetics that have been lost or stolen from the Member.

Major Restorations on Primary Teeth: Major Restorations, such as crowns, are limited to an allowance for stainless steel crowns.

Malignancies and Neoplasms: Services for treatment of malignancies and neoplasms. Histopathological exams (examination of cells by microscope) and/or the removal of tumors, cysts and foreign bodies.

Medically Necessary: Any services, supplies or treatment which are not Medically Necessary (see definitions).

No Charge Services: Services or supplies received for which no charge is made to the Member or for which no charge would be made to the Member in the absence of dental coverage.

Oral Hygiene: Charges for tobacco counseling, oral hygiene instruction, dietary planning or behavior management.

Personalization: Personalization or characterization of dentures or teeth.

Prescription Drugs And Medications: Any prescribed drugs, pre-medication or analgesia. Any charge for nitrous oxide or local anesthesia when billed separately from a covered dental procedure.

Professional Charges: Professional visits to the Member's home, extended care facility or hospital. Charges for office visits after regularly scheduled hours, case presentations and missed or cancelled appointments.

Professionally Acceptable Treatment: If more than one treatment plan would be considered Medically Necessary for a dental condition, any amount exceeding the cost of the Least Expensive, Professionally Adequate Treatment (see definitions) plan is not covered.

Prophylaxis Limits: Prophylaxis treatments exceeding two treatments in a Calendar Year or if the treatment is performed as part of a periodontal procedure.

Prosthetic Replacements: Replacement of a fixed or removable prosthesis for which benefits were paid by the Plan, if replacement occurs within five years of the original placement, unless: (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; (b) the existing denture or bridgework cannot be repaired, duplicated or made serviceable and, if the charges for its installation were Covered Services under any benefit section of this booklet; and (c) the existing denture is an immediate temporary denture and replacement by a permanent denture is required and takes place within 12 months from installation of the immediate temporary denture.

Prosthetics: Temporary and interim Prosthetics (temporary crowns, bridges, partials, dentures, etc., are considered an integral part of the final services rather than a separate service). Maxillofacial Prosthetics that repair or replace facial and skeletal anomalies.

Provider Related To Member: Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.

Replacement of Existing Restorations: Replacement of existing restorations for any purpose other than treatment of pathology or decay.

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

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

Services Provided Before or After the Term of This Coverage: Services received before the Member's Effective Date. Services received after the Member's coverage ends, except as specifically stated under **BENEFITS AFTER TERMINATION: TERMINATION AND RELATED PROVISIONS**.

Transfer of Care: If the Member transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one covered dental procedure, the Plan shall be liable only for the amount for which it would have been liable if one Dentist had rendered the services.

Treatment by an Unlicensed Dentist: Charges for treatment by other than a licensed Dentist except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a Dentist.

Treatment of the Joint of the Jaw and/or Occlusion Services: Diagnosis, services, supplies or Appliances provided in connection with any of the following:

- Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means.
- Any treatment, including crowns, caps and/or bridges to change the way the upper and lower teeth meet (occlusion).
- Treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down.
- Occlusal guards, occlusal adjustments (complete or limited) and occlusal analysis.

Unnecessary Replacements: Replacement of an existing denture that, in the opinion of the Dentist, is or can be made satisfactorily.

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

- Changing the vertical dimension
- Replacing or stabilizing tooth structure lost by attrition, abrasion, or erosion
- Realignment of teeth
- Gnathological recording
- Occlusal equilibration, except when needed to treat periodontal disease
- Periodontal splinting

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

X-rays: More than one set of full-mouth X-rays or its equivalent in a five-year period, unless required in connection with the diagnosis of a specific condition requiring treatment.

ORTHODONTIC CARE THAT IS NOT COVERED

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

Orthodontic Services Provided Before or After the Term of the Member's Coverage: Orthodontic treatment provided prior to the Member's Effective Date or after the termination of the Member's coverage.

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

THIRD PARTY LIABILITY

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

1. The Trust will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that the Member receives from the third party, the third party's insurer, or the third party's guarantor or any insurer. The lien shall be in the amount of benefits paid by the Trust under this Plan for the treatment of the illness, disease, injury or condition for which the third party is liable.
2. The Member agrees to advise Anthem in writing within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as may be required to facilitate enforcement of the Trust's rights. The Member must not take action which may prejudice the rights or interests of the Trust under the Plan.

   Failure of the Member to give such notice to Anthem or to cooperate with Anthem, or actions of the Member that prejudice the rights or interests of the Trust shall be a material breach of this Plan and shall result in the Member being personally responsible for reimbursing the Trust.
3. The Trust shall be entitled to collect on its lien even if the amount the Member or any person recovered for the Member (or the Member's estate, parent or legal guardian) from or for the account or such third party if compensation for the injury, illness or condition is less than the actual loss the Member suffered. This would also include, but is not limited to any monies recovered by means of an uninsured or under insured motorist policy.
4. The Plan's right to recover shall apply regardless of whether the Member is made whole.

WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of and does not affect any requirement of coverage by workers' compensation insurance. It also does not replace that insurance.

If, pursuant to any workers' compensation or employers' liability law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by the Trust, and such third party disputes that responsibility, the Trust shall provide the benefits of this Plan and the Trust shall automatically acquire thereby, by operation of law, a lien to the extent of the reasonable value of the services provided by the Trust

COORDINATION OF BENEFITS

If a Member is covered by more than one group dental plan, the Member's benefits under this Plan will be coordinated with the benefits payable by such other plans in accordance with the following provisions:

1. **DEFINITIONS**

   a. **Allowable Expense** is any necessary, reasonable and customary item of expense which is at least partially covered by at least one **other plan** covering the person for whom a claim is made. When a plan provides benefits in the form of services rather than cash reimbursement for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

   b. This **Plan** means the CAHP Dental Trust Plan.

   c. The **other plan** means any plan providing benefits or services for or by reason of dental care or treatment, which benefits or services are provided by any group, group service, group practice or any other prepayment coverage on a group basis or any coverage under labor management trustee plans, or group coverage sponsored by or provided through a school or educational institution.

   d. **Primary Carrier** means a plan that, according to the Order of Benefit Determination provisions below, has primary responsibility for the provision of benefits.

   e. **Secondary Carrier** means a plan that, according to the Order of Benefit Determination provisions below, has secondary responsibility for the provision of benefits after the Primary Carrier determines its benefits.

2. **Order of Benefit Determination**
   The rules for establishing the Order of Benefit Determination are:

   A plan that has no coordination of benefits provision pays before a plan that has a coordination of benefits provision.

   a. A plan that covers the Member other than as a dependent shall have primary responsibility for the provision of benefits before a plan that covers the Member as a dependent.

      When a plan covers the Member as a dependent and the parents are not separated or divorced, and each Spouse is covered by a group plan which covers the Member as a dependent, the plan of the Spouse with the earliest birth date in the Year shall have primary responsibility for the provision of benefits. If, however, either of the plans does not include the provisions of this paragraph, primary responsibility for the provision of benefits shall be determined by the plan that does not include these provisions.

   b. When a plan covers the Member as a dependent and the parents are separated or divorced, and the parent with custody of the Member has not remarried, the plan which covers the Member as a dependent of the parent with custody of the Member shall have primary responsibility for the provision of benefits before the plan which covers the Member as a dependent of the parent without custody.

   c. When a plan covers the Member as a dependent, and the parents are divorced and the parent with custody of the Member has remarried, the plan that covers the Member as a dependent of the parent with custody shall have primary responsibility for the provision of

benefits before the plan that covers the Member as a dependent of the step-parent. In addition, the plan that covers the Member as a dependent of the step-parent will determine its benefits before the plan that covers the Member as a dependent of the parent without custody.

d. When a plan covers the Member as a dependent, and the parents are separated or divorced and there is a court decree that would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to such Member, notwithstanding paragraphs 4 and 5 above, the plan that covers the Member as a dependent of the parent with such financial responsibility shall have primary responsibility for the provision of benefits before any other plan that covers the Member as a dependent.

e. When a plan covers an individual who is a laid-off or retired employee, or an individual who is dependent of such laid-off or retired employee, such plan shall determine its level of responsibility after any other plan covering that individual.

f. A plan which has no provision regarding laid-off or retired employees or their dependents, shall have primary responsibility for their benefits, if the lack of this provision would result in each plan determining its level of responsibility after the other.

g. The plan covering the Member under a continuation of coverage provision in accordance with state or federal law pays after a plan covering the Member as a Subscriber, 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 does not agree under these circumstances with the order of benefit determination provisions of this Plan, this rule will not apply.

3. Effect on Benefits

a. Primary Carrier

If this Plan is the Primary Carrier with respect to a Member, then this Plan will provide its services and benefits regardless of the benefits available to that Member from any other plan.

b. Secondary Carrier

If this Plan is a Secondary Carrier with respect to a Member, then this, Plan will provide its benefits in accordance with the following procedure:

In the event that the total amount of Allowable Expense incurred by that Member in any Calendar Year is exceeded by the sum of:

c. The amount of benefits that would be provided for such Allowable Expense under this Plan in the absence of these provisions, and
The amount of benefits that would be provided or would be payable for such Allowable Expense under all other plans in the absence therein of the same or any similar provisions. The services and benefits that would be provided under this Plan in the absence of these provisions shall be reduced to the extent necessary so that the sum of such reduced benefits when added to the benefits payable under all other plans shall not exceed the total of such Allowable Expense. Benefits payable under another plan include those benefits that would have been payable had a claim been duly made therefore.

4. **Provision of Benefits by Secondary Plan**
   With respect to the provisions of Section C. 2., the Secondary Carrier shall provide the services and benefits of this Plan as if it were the Primary Carrier. Members who receive services and benefits from the Secondary Carrier are hereby deemed to have assigned the benefits to the Secondary Carrier that they would have otherwise received from the Primary Carrier. By virtue of the provisions of this Plan, Members (a) agree to cooperate fully with Anthem in completing the necessary assignments to enable this Plan to obtain payment of benefits from the Primary Carrier, and (b) agree to reimburse this Plan from the benefits paid to the Member by the Primary Carrier for the services and benefits also provided by this Plan.
5. **Optional Payment of Benefits**
   Whenever services which should have been provided under this Plan in accordance with these provisions have been paid as benefits under any other plan, this Plan shall have the right to pay to such other plan any amounts that it determines to be necessary in order to satisfy the intent of these provisions. Such amounts shall be considered to be benefits provided under this Plan and, to the extent of such payments, the Trust shall be fully discharged from liability under this Plan.
6. **Right of Recovery**
   Whenever this Plan has made payments, or has provided covered services in excess of the amount determined in accordance with these Coordination of Benefits provisions, this Plan shall have the right to recover such payments or the reasonable cash value of such covered services, to the extent of such excess, from one or more of the following, as this Plan shall determine: 1) any person(s) to or for or with respect to whom such payments were made or services provided, 2) any other plans, 3) insurers, 4) service plans, or 5) any other organization. If a Member is covered under any other plan and the contract or plan documents of such other plan contain Coordination of Benefits provisions, this Plan shall be deemed a third party beneficiary of such provision.

ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT

1. All Members who are eligible in accordance with the Act may enroll hereunder. Enrollment is restricted to eligible, dues-paying Members and permanent Employees of the California Association of Highway Patrolmen and their eligible Family Members.
2. Any Employee appointed into State Service on or after January 1, 1992, and eligible in accordance with the Act, must complete 24 qualifying pay periods of State Service prior to enrolling in a fee-for-service dental plan.
3. Employees who retire on or after September 30, 1992, will be permitted to continue or enroll in the Trust plan. Once a retiree has elected to enroll in the Trust plan, that retiree shall not be permitted to transfer enrollment into any other State sponsored dental plan.
4. An Employee, Annuitant or Family Member shall not be eligible for enrollment with this Plan while enrolled under any of the State of California's alternative dental benefit programs.

CONDITIONS OF ENROLLMENT

1. Each Employee or Annuitant who is eligible to become a covered Subscriber according to the provisions stated under this **ENROLLMENT PROVISIONS** section, and who files application for membership for himself or herself and his or her eligible Family Members on forms provided by the Employer with the Employer during an Open Enrollment Period or period of initial eligibility, as specified in the Act, shall have fulfilled the Conditions of Enrollment.
2. If an Employee or Annuitant fails to enroll himself or herself or his or her eligible Family Members during an Open Enrollment Period or the period of initial eligibility as specified in the Act, Anthem, on behalf of the Trust, shall have the right to refuse such enrollment until the next Open Enrollment Period; except that an Employee or Annuitant may apply for enrollment for himself or herself and any eligible Family Members in accordance with the Act. Contact your Employer or the CalPERS Benefits Division (Annuitants) for information regarding late enrollment.

IMPORTANT NOTE: It is the Subscriber's responsibility to request additions, deletions or changes in enrollment in a timely manner and to stay informed about the eligibility requirements in the Act and Regulations. The Subscriber shall be held liable retroactively for any services provided to ineligible Members.

COMMENCEMENT OF COVERAGE

After fulfilling the Conditions of Enrollment as stated above, coverage shall commence for a Subscriber and his or her Family Members at 12:01 a.m. on the date set forth in the Act.

TERMINATION AND RELATED PROVISIONS

VOLUNTARY CANCELLATION

A Member may cancel his or her enrollment in this Plan established in accordance with the Act and Regulations and shall cease to be covered without notice from the Trust or Anthem at midnight on the day on which such cancellation of enrollment becomes effective, under the Act.

REENROLLMENT

Members who have voluntarily cancelled enrollment under this Plan may apply for reenrollment during the Open Enrollment Period.

TERMINATION OF ENROLLMENT AND COVERAGE

The enrollment in this Plan of a Member shall be terminated in accordance with the Act and Regulations or by the Trust's termination of the Plan, subject, however, to the extensions of coverage required of the Act and Regulations and the continuation benefits provided under **CONTINUATION OF COVERAGE**.

CONTINUATION OF COVERAGE (COBRA)

The COBRA (Consolidated Omnibus Budget Reconciliation Act) group continuation coverage is provided through federal legislation and allows an enrolled Employee or Annuitant or his or her enrolled Family Member who loses his or her regular group coverage under this Plan because of certain events to continue coverage for 18 to 36 months.

A. Eligibility for Continuation - Qualifying Events

Subscribers or Family Members may choose to continue coverage under the Plan if it would otherwise end for any of the reasons shown below. These are called qualifying events, and they are:

For Subscribers and Family Members:

1. The Subscriber's termination, for any reason other than gross misconduct;
2. A reduction in the Subscriber's work hours;
3. For Members who may be covered as retirees, cancellation of that retiree coverage due to the Trust's filing for protection under the bankruptcy law (Chapter 11), provided the Member was covered prior to the filing of bankruptcy.

For Family Members:

4. The death of the Subscriber;
5. The Spouse's divorce or legal separation from the Subscriber or if the Spouse vacates the residence shared with the Subscriber;
6. The end of a child's status as a Family Member, in accordance with the Act or Regulations.

A Subscriber or Family Member is not eligible to continue coverage if, at the time of the qualifying event, such person is covered under any other group dental plan. However, if a Member is ineligible to continue coverage for these reasons, the other eligible Family Members may still choose to continue their coverage.

B. Requirements for Continuation

1. **Notice**

   For qualifying events 1, 2 and 3, on the previous page, the Subscriber's Employer will notify the Subscriber of the right to continue coverage. In the event of the Subscriber's death (4, above), a Family Member will be notified of the continuation right. Anyone choosing to continue coverage must so notify CalPERS/Employer within 60 days of the date they receive notice of their continuation right.

   In the event of an Annuitant's death, it is the Family Member's responsibility to notify CalPERS/Employer within 60 days of the date such qualifying event occurred.

   The Member must inform the Trust of qualifying events 5 or 6, above, within 60 days of such event if the Family Member wishes to continue coverage. If the Subscriber or Family Member fails to provide such timely notice to CalPERS/Employer, then such person shall not be entitled to elect continuation coverage.

   Within 14 days of receipt of timely notice of the qualifying event, CalPERS/Employer shall provide written notice to eligible Subscribers and Family Members of their continuation right at the address of such persons on the records of CalPERS/Employer. Such notice to an Employee or Annuitant or his or her Spouse shall be deemed notice to all other eligible Family Members residing with such Subscriber, Annuitant or Spouse at the time such notification is made.

   The continuation coverage may be chosen for all Members within a family, or only for selected Members. However, if a Member fails to elect the continuation when first eligible, that person may not elect the continuation at a later date.

   Once an Employee, Annuitant or Family member elects the COBRA continuation, the Trust shall provide written notice of their rights to continuation of coverage. In addition to the written notice, an Evidence of Coverage booklet will be sent to the enrolled Subscriber at his or her address on enrollment document(s) and shall be deemed notice to such Subscriber and his or her spouse.

2. **Family Members Acquired During Continuation**

   A Spouse or child newly acquired during the continuation period is eligible to be enrolled as a Family Member. The standard enrollment provisions of the Plan apply to enrollees during the continuation period. A Family Member acquired and enrolled during the period of continuation coverage which resulted 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*.

   ***Exception:** A child who is born to, or placed for adoption with the Subscriber during the COBRA continuation period will be eligible for a separate continuation if a subsequent qualifying event results in the person's loss of coverage.

C. **Cost of Coverage**

The benefits of continuation coverage are identical to the benefits in this Evidence of Coverage Form. The required monthly contribution for continuation coverage may not exceed 102 percent of the prepayment fees specified for coverage under this Plan or any amendment, renewal or replacement of this Plan. An eligible Subscriber or his or her eligible Family Member(s) electing continuation coverage shall pay to the Trust the required monthly contribution for continuation coverage no later than the following dates:

a. If such election is made before the qualifying event, the required monthly contribution may be paid with the written election, in the amount required for the first month of continuation coverage.
b. If such election is made after coverage is terminated due to a qualifying event, the required monthly contribution for the period of continuation of coverage preceding the election shall be made within 45 days of the election together with the required monthly contribution for the period beginning with the date of election and ending on the last day of the month in which the required monthly contribution is paid for the period preceding the election. It is the intention of this provision to require that the initial required monthly contribution payment include required monthly contributions due for continuation coverage from the date coverage terminates under the group Plan to the end of the month in which the initial required monthly contribution is paid.

   Thereafter, the required monthly contribution shall be paid on or before the first day of each month for which continuation coverage is to be provided. If any required monthly contribution for continuation coverage is not paid when due, the Trust may issue a notice of cancellation of continuation of coverage. If payment is not received within 15 days of issuance of such notice of cancellation, the Trust may cancel the continuation coverage on the sixteenth day following issuance of notice of cancellation. Termination of coverage shall be retroactive to the first day of the month for which the required monthly contribution has not been received.

   For a Subscriber who is eligible for an extension of continuation coverage due to having been determined by the Social Security Administration to be totally and permanently disabled, the Trust shall charge 150 percent of the Subscriber's required monthly contribution prior to the disability. The Trust must receive timely payment of the required monthly contribution each month in order to maintain the coverage in force.

   If a second qualifying event (as shown below) occurs during this extended continuation, the total COBRA continuation may continue up to 36 months from the date of the first qualifying event. The required monthly contribution shall then be 150% of the applicable rate for the 19th through 36th months.

   For purposes of determining required monthly contributions payable for continued coverage, a person originally covered as a Spouse will be treated as the Subscriber if coverage is continued for him or her alone. If such Spouse and his or her child(ren) enroll, the required monthly contribution payable will depend upon the number of persons covered. Each child continuing coverage other than as a dependent of a Subscriber will pay the required monthly contribution applicable to a Subscriber. (If more than one child is so enrolled, the required monthly contribution shall be the two-party or three-party rate, depending upon the number of children enrolled.)

D. **Subsequent Qualifying Events**

Once covered under the continuation plan, it's possible for a secondary qualifying event to occur. If that happens, a Family Member may be entitled to a second continuation period. This period will in no event continue beyond 36 months from the date the Member's coverage terminated to the first qualifying event. Except for newborn or newly adopted children as

described above, only a Member covered prior to the original qualifying event is eligible to continue coverage again as the result of a later qualifying event. A Family Member acquired during the continuation coverage is not eligible to continue coverage as the result of a later qualifying event, with the exception of newborns and adoptees as described above.

For Example: Continuation may begin due to termination of employment. During the continuation, if a child reaches the proper age limit of the Plan, the child is eligible for a second continuation period. This second continuation period would end no later than 36 months from the date coverage was terminated due to the first qualifying event - the termination of employment.

E. When Continuation Coverage Begins

When continuation coverage is elected and the required monthly contribution is paid, coverage is reinstated back to the date the Member's coverage was terminated due to the qualifying event, so that no break in coverage occurs. Coverage for Family Members acquired and properly enrolled during the continuation begins in accordance with the enrollment provisions of the Act and Regulations.

F. When the Continuation Ends

This continuation will end on the earliest of:

1. The end of 18 months from the date the Member's coverage terminates, if the qualifying event was termination of employment or reduction in work hours. For a Member whose continuation coverage began under a prior plan, this term will be dated from the time the Member's coverage terminates under that prior plan due to the qualifying event.
2. The end of 36 months from the date the Member's coverage terminates, if the qualifying event was the death of the Subscriber; divorce or legal separation; or the end of dependent child status. For a Member whose continuation coverage began under a prior plan, this term will be dated from the time the Member's coverage terminated under that prior plan due to the qualifying event.
3. The date the Plan terminates.
4. The date the member becomes covered under any other group dental plan.
5. The end of the last period for which the final required monthly contribution was paid.

   In the event that the Member is eligible for both continuation coverage under any other group dental plan, the continuation benefits may be reduced so that the benefits and services the Member receives from all group coverage do not exceed **100** percent of the Maximum Allowed Amount incurred.

Subject to the Plan remaining in effect, a retired Subscriber whose coverage began due to a Chapter 11 bankruptcy may continue coverage for the remainder of his or her life; that person's covered Family Members may continue coverage for 36 months after their coverage terminates due to the Subscriber's death. However, coverage could terminate prior to such time for either the Subscriber or Family Member in accordance with items 3, 4 or 5 above.

BENEFITS AFTER TERMINATION

If you are Totally Disabled and under the treatment of a Dentist on the date of termination of this Plan or of discontinuance of coverage offered by this Plan, your benefits may be continued for treatment of the totally disabling dental condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

A. If you wish to apply for total disability benefits after termination, you must do so by submitting written certification by your Dentist of the total disability. Anthem must receive this certification within 90 days of the date coverage ends under this Plan. At least once every 90 days while benefits are extended, Anthem must receive proof that your total disability is continuing.
B. Your extension of benefits will end when any one of the following circumstances occurs:
    1. You are no longer Totally Disabled, or
    2. The maximum benefits available to you under this Plan are paid, or
    3. You become covered under another group plan which provides benefits without limitation for your disabling dental condition, or
    4. A period of 12 months has passed since your extension began.

GENERAL PROVISIONS

MEDICALLY NECESSARY/LEAST EXPENSIVE, PROFESSIONALLY ADEQUATE TREATMENT

The benefits of this Plan are provided only for services that are Medically Necessary. The services must be ordered by the attending Dentist for the direct care and treatment of a covered condition. They must be standard dental practice where received for the condition being treated and must be legal in the United States. In addition, if more than one treatment plan is considered Medically Necessary for a dental condition, benefits of this Plan are provided up to the cost of the Least Expensive, Professionally Adequate Treatment.

EVIDENCE OF COVERAGE

The Trust shall issue to the Subscriber an Evidence of Coverage booklet. This Evidence of Coverage is not the Agreement. It does not change the coverage under the Plan in any way. This Evidence of Coverage, which is a written description of the benefits provided under the Plan, is subject to all of the terms and conditions of the Plan.

WORKERS' COMPENSATION INSURANCE

The Plan does not affect any requirement of coverage by workers' compensation insurance. It also does not replace that insurance.

PROTECTION OF COVERAGE

Neither the Trust nor Anthem has the right to cancel the coverage of any Member under this Plan while:

The Administrative Services Agreement between Anthem and the Trust is still in effect, and

- The Member is still eligible, and
- The Member's required monthly contributions are paid according to the terms of the Plan.

PROVIDING OF CARE

The Trust and Anthem are not responsible for providing any type of dental care. Also, the Trust and Anthem are not responsible for the quality of any type of dental care received.

NON-REGULATION OF PROVIDERS

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 Providers.

AREA OF SERVICE

The benefits of this Plan are provided for covered services received anywhere in the world.

IDENTIFICATION CARDS AND EVIDENCE OF COVERAGE BOOKLETS

Anthem, on behalf of the Trust, shall issue to the Subscriber and Family Members an identification card. The Trust shall issue to the Member an Evidence of Coverage booklet setting forth a statement of the services and benefits to which the Member and Family Members are entitled. Possession of an

identification card confers no right to services or other benefits of this Plan. To be entitled to services or benefits, the holder of the card must, in fact, be a Member on whose behalf applicable fees under this Plan have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Plan is chargeable therefore at prevailing rates.

FREE CHOICE OF PROVIDER

This Plan in no way interferes with the right of any person entitled to dental benefits under the Plan to select the dental care professional or facility of his or her choice. That person may choose any provider that is properly licensed according to appropriate state and local laws. However, that person's choice may affect the benefits payable according to the terms of the Plan.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of enforcing or interpreting this Plan, or participating in resolving any matter in dispute in regard to this Plan, the Trust, Anthem, the Board, DPA, or any person covered under this Plan agrees, subject to statutory requirements, to share all relevant information with any other party. Such information may only be used in determining the disputed matter, and shall not be further disclosed without the consent of the person(s) to whom the information pertains. Any exchange of information pursuant to this section, for the limited purposes of this section, shall not be deemed a breach of any person's right of privacy.

For the purposes of enforcing, determining the applicability of, and implementing the Coordination of Benefits provisions of this Plan or any similar provisions of any other plan, the Plan may release to, or obtain from, any other plan, dental care provider, insurance company, organization or person, any information, with respect to any person, which the Plan deems to be necessary for such purposes. Members shall furnish such information as may be necessary to implement these provisions.

LIABILITY OF MEMBER FOR CERTAIN CHARGES

In the event the Plan fails to pay a Provider who contracts with Anthem for covered services, the Member shall not be liable to the Provider for any sums owed by the Trust.

In the event the Plan fails to pay a Non-Participating Provider, the Member may be liable to pay that Provider any amounts not paid to them by the Plan.

The Member is liable for all expenses in excess of the benefits of this Plan.

EXPENSE IN EXCESS OF BENEFITS

Anthem and the Trust are not liable for any expense the Member incurs in excess of the benefits of this Plan.

PAYMENT TO PROVIDERS

The benefits of this Plan will be paid directly to Participating Providers. Also, Non-Participating Providers may be paid directly when the Member assigns benefits in writing. These payments fulfill the obligation of the Trust to the Member for those services.

RIGHT OF RECOVERY

When the amount paid exceeds the amount for which the Trust is liable under this Plan, the Trust has the right to recover the excess amount. This amount may be recovered from the Member, the person to whom payment was made or any other plan.

BENEFITS NOT TRANSFERRABLE

Only eligible Members are entitled to receive benefits under this Plan. The right to benefits cannot be transferred.

CLERICAL ERROR

No clerical error on the part of the Employer, the Trust or Anthem shall operate to defeat any of the rights, privileges or benefits of any Member.

INDEPENDENT CONTRACTORS

Anthem's relationship with all Providers is that of an independent contractor. Dentists and other dental health professionals are not Anthem's agents nor is Anthem or any of its employees, an employee or agent of any dental group or dental care provider of any type. Neither the Trust nor Anthem is liable for any claim or demand for damages connected with any injury resulting from any treatment.

TERMS OF COVERAGE

In order for a Member to be entitled to benefits under the Plan, both the Plan and the Member's coverage under the Plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.

The benefits to which a Member 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 the Member receives the service or supply for which the charge is made.

The Plan is subject to amendment, modification or termination according to the provisions of the Plan without the consent or concurrence of Members.

MEMBER COOPERATION

By virtue of the Trust's agreement with CalPERS, Members agree to: (a) take action, furnish help and information and execute instruments required to enforce the Trust's rights as set forth in the Administrative Services Agreement; (b) take no action to harm the Trust's rights or interests; and (c) notify the Trust or Anthem, on behalf of the Trust, of circumstances that may give rise to its rights.

GRIEVANCE/CLAIMS REVIEW PROCEDURE

STEP 1: DISAGREEMENTS WITH ANTHEM'S CLAIMS DETERMINATION

The Plan provides that treatment or service must be Medically Necessary and covered under this Plan. The fact that the Member's attending Dentist may prescribe, order, recommend or approve a service or treatment does not, in itself, make the service or treatment an allowable expense, even if it is not specifically listed in this Evidence of Coverage Form as an exclusion. Anthem has the responsibility for determining whether claims are payable. Action on your claim, including any denial, will be given in writing by Anthem, including the reason for any denial. A practicing dentist-consultant retained by Anthem must agree if the denial is based on the lack of medical necessity.

Grievances

If you have a Grievance about any aspect of service, such as the processing of a dental claim, dental treatment or services rendered, you should first contact customer service. You may file a verbal Grievance by either calling the toll-free number indicated below or by submitting a written Grievance to the following address:

BC Life & Anthem Blue Cross Life and Health Insurance Company
Grievance Department
PO Box 659471
San Antonio, TX 78265
1-800-627-0004

Anthem will acknowledge receipt of the Grievance by written notice and provide a resolution within 30 days of receipt. A trained representative will work with you to resolve the Grievance. If after working with customer service you are not satisfied with the resolution of your Grievance, you may file an Appeal as explained in the Appeals section which follows.

Appeals

You may file an Appeal either verbally or in writing. Anthem will acknowledge receipt of the Appeal and provide a resolution within the State of California's specified Appeal resolution time frames. A trained representative will work to resolve the Appeal which will be reviewed by an individual not previously involved in the original decision.

An Appeal may be filed with or without having first submitted a formal Grievance. In the Appeal, please state plainly the reason(s) why the claim, requested treatment or service should not have been denied. Any documents or information not originally submitted that may have a bearing on Anthem's decision should be included.

For pre-treatment denials based on utilization review, an expedited Appeal and/or expedited independent external review may be available to you based on state specific requirements.

In the case of a benefit denial based on a retrospective review, an independent external review Appeal may also be available based on state specific requirements.

Written Appeals can be sent to the following address, or you can call Anthem at the toll-free phone number listed below:

BC Life &Anthem Blue Cross Life and Health Insurance Company
Appeals Department
PO Box 659471
San Antonio, TX 78265
1-800-627-0004

You may designate a representative (e.g., your healthcare Provider or anyone else of your choosing) to file a Grievance or Appeal on your behalf. Anthem must receive a written designation from you in order to work with your representative.

The Grievance and Appeals process is governed by laws and regulations and may be modified from time to time by Anthem as those laws may require. A more detailed description of the Grievance and Appeals process and the decision making timeframes is set forth in Anthem's Grievance and Appeals Guide. You may request a copy of this guide by calling customer service at **1-800-627-0004**.

Both TTY/TDD services for the hearing and speech impaired and language translation assistance are available upon request to assist the you in filing a Grievance or Appeal.

If Anthem affirms the denial or fails to respond within 30 days after receiving your written request for review and you still disagree, you may proceed to **STEP 2: Trust's Claims Review** or **STEP 3: Binding Arbitration**.

Note: You should follow Anthem's Grievance and Appeal procedures detailed above for disputes over coverage and/or benefits or if you are dissatisfied with the quality of care or your access to care. For matters of eligibility, Active Employees should contact the benefits officer in their agency or Department of Human ResourcesCalifornia Department of Human Resources (CalHR) (CalHR) at (916) 322-0300, and Annuitants should contact CalPERS Office of Employer and Member Health Services at PO Box 942714, Sacramento, CA 94229-2714 or call 1-888-225-7377.

For Grievances and/or Appeals not resolved after completing **STEP 1** procedures:

A. **Covered grievances:** If you have followed Anthem's Grievance and/or Appeals procedure(s) listed above and are still dissatisfied, you may proceed to **STEP 2: Trust's Claims Review** or **STEP 3: Binding Arbitration** (**Small Claims Court)**. If your coverage/benefit dispute is within the jurisdictional limits of small claims court, you must proceed through that court.
B. **Eligibility grievances:** These issues should always and only be referred directly the benefits officer in your agency or Department of Human ResourcesCalifornia Department of Human Resources (CalHR) (CalHR) for Active Employees or, for Annuitants, CalPERS Office of Employer and Member Health Services at the phone numbers indicated in the Note above.
C. **Malpractice grievances:** Claims of malpractice must be taken up directly with the Provider of dental care.
D. **Bad faith grievances:** You must proceed to **STEP 3: Binding Arbitration (or Small Claims Court)** for claims for benefits involving charges of bad faith.

STEP 2: TRUST'S CLAIMS REVIEW

Except for determination of Maximum Allowed Amount, a Member aggrieved by a decision of the Claims Administrator after reconsideration of a denied claim may request further review by the Trust. Such request must be in writing and must include the reason for the request for further review and all pertinent documents and data.

Mail the request for Trust's Claims Review to:

CAHP Dental Trust
2030 V Street
Sacramento, CA 95818-1730

Such request must be submitted to the Trust no later than 30 days following Anthem's final determination of non-payment. If you do not wish to request further review from the Trust, you may proceed to **STEP 3**.

The Plan's final determination under claims review shall be made by the Trust within 30 days as to whether any of the terms, conditions, reductions, limitations or exclusions of the Plan apply so as to preclude services or benefits that would otherwise be provided herein. The Trust shall make its determination after review and consideration of (1) all written information submitted by the Member and (2) information received from Anthem. The Trust shall exercise the option to request additional information, or to schedule the review as an agenda item at the quarterly Trustees' meeting. Under these circumstances, the 30-day limitation for determination will not apply.

If the Trust affirms Anthem's denial and you still disagree, you may proceed to **STEP 3**.

STEP 3: BINDING ARBITRATION (SMALL CLAIMS COURT)

If you do not use **STEP 2** or it does not apply, binding arbitration is the final step in resolving your grievance, except any dispute regarding a claim for damages within the jurisdictional limits of the small claims court must be resolved in such court. **A small claims court judgment cannot be appealed.**

By enrolling in this Plan, you agree to waive your constitutional right to have any such claim decided in a court of law or before a jury and instead accept the use of binding arbitration.

The steps for binding arbitration are as follows:

A. Binding arbitration is begun by you making written demand on Anthem.
B. 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 you and Anthem, or by order of the court if you and Anthem cannot agree. Copies of such arbitration rules are available from Anthem.
C. <u>THE ARBITRATION FINDINGS ARE FINAL AND BINDING</u>, except to the extent that California law provides for judicial review of arbitration.

Questions about your right of appeal, all notices required of you to initiate these rights and any demand for arbitration not available through the local dental society should be directed to Anthem, PO Box 659444 San Antonio, TX 78265, Attn: Claims Appeal Department.

GENERAL DEFINITIONS

When any of the following terms are capitalized in this Evidence of Coverage Form, they will have the meaning below. This section should be read carefully. Defined terms have the same meaning throughout this Evidence of Coverage Form.

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. Damage to teeth due to chewing or biting is not an accidental injury.

Act means the California Public Employees' Retirement Law under the State Employees' Dental Care Act (Government Code 22952 and 22953) and as stated in the Memorandum of Understanding (MOU).

Annuitant is defined in accordance with the definition currently in effect in the Act and Regulations, refers to retired Employees of the State of California, and vested retired Employees of the California Association of Highway Patrolmen.

Appeal is formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of Anthem who did not previously render an opinion on the resolution of your Grievance.

Appliance is a dental device designed to perform a therapeutic or corrective function.

Anthem Blue Cross Life and Health Insurance Company and **Anthem Blue Cross (Anthem)** – Anthem Blue Cross Life and Health Insurance Company is licensed by the California Department of Insurance as a life and disability insurer. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of dental claims under the Plan. Both Anthem Blue Cross Life and Health Insurance Company and Anthem Blue Cross are indirect wholly owned subsidiaries of WellPoint, Inc., an Indiana-domiciled commercial health benefits company.

Board means the Board of Administration of the California Public Employees' Retirement System (CalPERS).

CAHP is the California Association of Highway Patrolmen.

Claims Administrator refers to Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association (BCA).

Coinsurance is the percentage of the Maximum Allowed Amount which you are responsible to pay.

Covered Services are services or treatment as described in the Plan which are performed, prescribed, directed or authorized by a Provider. To be considered Covered services, services must be:

1. Within the scope of the license of the Provider performing the service;
2. Rendered while coverage under this Plan is in force;
3. Medically Necessary*;*
4. Not specifically excluded or limited by the Plan; and
5. Specifically included as a benefit within the Plan.

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

Effective Date is the date the Member's coverage begins under this Plan.

Employee is defined in accordance with the definition currently in effect in the Act and Regulations, and includes the California Association of Highway Patrolmen.

Employer is defined in accordance with the definition currently in effect in the Act and Regulations, and includes the California Association of Highway Patrolmen.

Evidence of Coverage Form (Evidence of Coverage) is this written description of the benefits provided under the Plan.

Experimental Procedures are procedures not yet recognized by the American Dental Association as indicated with a specific procedure designation, or procedures which are not widely accepted as proven and effective procedures within the organized dental community.

Family Member means the spouse and children of an Employee or Annuitant who qualify under the Act and Sections 22952.1, 22953 and 22957.5 of the Regulations and the Spouses and children of an eligible Employee or vested retired Employee of the California Association of Highway Patrolmen. In addition, a Family Member shall include a Domestic Partner as defined in section 22868 of the Act.

Grievance is any expression of dissatisfaction made by you or your representative to Anthem in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with Anthem on the day and time it is received. Grievances may include, but are not limited to, concerns about:

1. the availability of Providers;
2. the handling or payment of claims for dental care services;
3. matters pertaining to the contractual relationship between you and the Plan.

Least Expensive, Professionally Adequate Treatment refers to services, and supplies provided in connection with those services, determined under the Plan to be:

1. Acceptable and necessary for the symptoms, diagnosis, or treatment of the Member's dental condition.
2. Provided for the prevention, diagnosis, or direct care and treatment of the dental condition.
3. Within community standards of good dental practice.

Maximum allowed amount is the maximum amount of reimbursement Anthem will allow for covered medical services and supplies under this Plan. See How Maximum Allowed Amount Is Determined.

Medically Necessary procedures, services or treatments are those which are:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the dental condition;
2. Customarily provided for the prevention, diagnosis, or direct care and treatment of the dental condition;
3. In accordance with generally accepted standards of dental practice;
4. Not primarily for your convenience, or the convenience of your Dentist or another provider; and
5. Based on prevailing dental practices, the least expensive covered service suitable for your dental condition according to generally accepted standards of dental practice.

For these purposes "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by Providers in the state where the care is provided.

Member means any Employee, Annuitant or Family Member enrolled under this Plan.

Non-Participating Provider is a Provider who has NOT entered into a contractual agreement with Anthem at the time services are rendered.

Open Enrollment Period means a period of time established by the California Department of Human Resources Administration (CalHR) during which eligible Employees and Annuitants may enroll in a dental plan, add Family Members, or change their enrollment from one dental benefits plan to another.

Participating Provider is a Provider who has entered into a contractual agreement with or is otherwise engaged by Anthem, or another organization which has an agreement with Anthem, to provide Covered Services and certain administrative functions for one or more of the following three Dental Blue PPO networks: Dental Blue 100, Dental Blue 200, and/or Dental Blue 300. A directory of Participating Providers is available on Anthem's website at **www.anthem.com/ca**, or you may call customer service at 1-800-627-0004.

Plan is the CAHP Dental Trust Dental Blue Plan, the set of benefits described in this Evidence of Coverage and the Administrative Services Agreement the Trust has with Anthem Blue Cross Life and Health Insurance Company.

Prosthesis (prosthetics) is a restorative service used to replace one or more missing or broken teeth and associated tooth structures. It includes all types of crowns, pontics, inlays, onlays, bridges and dentures.

Provider is a duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the plan approves. This includes any provider rendering services which are required by applicable state law to be covered when rendered by such provider.

Subscriber means the person enrolled hereunder who is responsible for payment to the Trust, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this Plan. Subscribers must be members or eligible permanent Employees or vested retirees of the California Association of Highway Patrolmen.

Spouse is the Subscriber's Spouse under a legally valid marriage. A **Totally Disabled** active employee is unable, because of illness or injury, to work for income in any job for which her or she is qualified or for which he or she becomes qualified by training or experience, and is in fact unemployed. An Annuitant or Family Member is Totally Disabled when he or she is unable to perform all activities usual for a person of that age.

Treatment Plan is a detailed description, submitted by the Provider, outlining the proposed services and fees including any appropriate radiographs and diagnostic information.

Trust is the CAHP Dental Trust.

Year (Calendar Year) is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time and ending on January 1 of the next following year.

You (your) refers to the Subscriber and Family Members who are enrolled for benefits under this Plan.

CAHP Dental Trust
2030 V Street
Sacramento, CA 95818-1730

(800) 734-2247
(916) 452-6751

Anthem Blue Cross
Attn: CAHP Dental Claims Unit
P.O. Box 659444
San Antonio, TX 78265
(800) 627-0004
www.anthem.com/ca

CAHP Dental Trust

Preferred Provider Organization
Sponsored by
The California Association of Highway Patrolmen

Dental claims administered by
Anthem Blue Cross
on behalf of Anthem BC Life & Health Insurance Company