CITY'S ORIGINAL

19641

PACIFICARE DENTAL
DENTAL SERVICES GROUP SUBSCRIBER AGREEMENT
COVER SHEET
(This cover sheet is an integral part of this Agreement)

GROUP NAME: CITY OF LONG BEACH

GROUP NUMBER: 11104, 10059 and 10060

ORIGINAL EFFECTIVE DATE: August 01, 1987

PLAN ID: V1200004 PLAN NAME: Signature Value 120

EFFECTIVE DATES FOR THIS PLAN REFLECT THE PLAN YEAR OF:
December 01, 2004 through November 30, 2006

PREMIUMS DUE ON OR BEFORE (ref. Section 3.06): 20th of each month
ANNUAL COPAY MAXIMUM PER INDIVIDUAL: None
ANNUAL COPAY MAXIMUM PER FAMILY: None

ELIGIBILITY:

Eligibility for dependent children is through age: 18
Eligibility for full-time students is up to age: 25

Start and End date of coverage (ref. Sections 2.04, 9, 10):

New spouse or child eligible on date of marriage or birth when added within 31 days of marriage or birth.

ATTACHMENTS: (The following attachments are an integral part of this agreement)

A Plan Design
B Limitation of Benefits
B-1 Governing Policies
C Exclusion of Benefits
D Orthodontics
E Prepayment Fees

PACIFICARE DENTAL PLAN

DENTAL SERVICES GROUP SUBSCRIBER AGREEMENT

FOR PREPAID PLANS ONLY

DENTAL SERVICES GROUP SUBSCRIBER AGREEMENT

PACIFICARE DENTAL, a California Corporation, hereinafter called "PD," and the employer, association or other entity specified as "GROUP" on the Cover Sheet, hereinafter called "Group," agree as follows:

RECITAL OF FACTS

PD is a specialized health care service plan which arranges for the provision of dental services to persons enrolled as Members on a prepaid and direct services basis through contracts with associations of licensed dentists and other health care providers, for and on behalf of its individual Members. The Group is an employer, organization or association which desires to provide such health care for its eligible Subscribers and family dependents. In consideration of the application of the Group for the benefits provided under this Agreement, and in consideration of the periodic payment of premiums on behalf of Members in advance as they become due, PD agrees to manage or provide dental and related health care benefits subject to all terms and conditions of this Dental Services Group Subscriber Agreement, including the Cover Sheet, and Attachments.

1. DEFINITIONS

Agreement is this Dental Group Subscriber Agreement, including but not limited to the Cover Sheet, appropriate Attachments, and any amendments hereto.

Benefits Review Committee is a committee composed of Plan personnel which reviews benefits and claims issues as the second level in the claims review process.

Copayments are fees payable pursuant to this Agreement by the member at the time of provision of services to a dental care provider which are in addition to the Dental Plan Premiums paid by the Group. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

Commissioner shall mean the Commissioner of the Department of Managed Health Care of the State of California.

Continuation Member is any individual who is enrolled and eligible to receive benefits under Paragraph 11.01 or 11.02 of this Agreement.

Cosmetic Dentistry is any dental procedure which is performed solely for cosmetic purposes and where there is not restorative value.

Cover Sheet is the Dental Group Subscriber Agreement Cover Sheet which is an integral part of this Agreement.

Covered Services are the Dental Services which are arranged or reimbursed by the Plan and are set forth in Exhibits A and B of this Agreement, subject to the limitations and exclusions provided herein.

Dental Care Expense is the expense incurred by a Participating Dental Group/IPA/Dentist for the care and treatment of a Member. The expense is computed in accordance with the Provider's fee schedule

Dental Plan is the Dental Plan described in this PD Dental Services Group Subscriber Agreement, Cover Sheet and Attachments.

Dental Plan Premiums are amounts established by PD to be paid to PD by the Group on behalf of Members in consideration for the benefits provided under this Dental Plan; such amounts are set forth in the Cover Sheet of this Agreement.

Dental Services unless otherwise stated in this Agreement, are the Medically Necessary professional services of Dentists including therapeutic services and preventative services which are performed, directed or authorized by a Member's Participating Dental Group/IPA/Dentist.

Dentist includes any duly-licensed dentist.

Dependent is any Spouse, unmarried child (including step-child, child placed for the purposes of adoption or adopted child) of Subscriber who is enrolled hereunder who meets all the eligibility requirements set forth in Paragraph 2.03 and for whom applicable Dental Plan Premiums are received by PD.

Elective Dentistry is any dental procedure which is unnecessary to the dental health of the patient, as determined by a Provider affiliated with the Plan and which is not covered by the Plan.

Emergency Services are Medically Necessary dental services required as a result of a dental condition manifesting itself by the sudden onset of symptoms of sufficient severity, which may include severe pain, such that the absence of immediate dental attention could reasonably be expected to result in: (1) placing the Member's dental health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Enrollment is the execution of the PD Enrollment Form by the Subscriber on behalf of the Subscriber and his or her Dependents, and acceptance thereof by PD, conditional upon the execution of this Agreement by the Group and PD and the timely payment of applicable Dental Plan Premiums by the Group. PD may, in its discretion and subject to specific protocols, accept enrollment through an electronic submission from the Group.

Enrollment Packet is the packet of information supplied by PD to prospective Members which summarizes this Dental Services Group Subscriber Agreement and contains the PD Enrollment Form.

Executive Review Committee consists of the PD Director of Compliance, Manager of Member Appeals, Vice President of Operations, licensed dental professional, and on an ad hoc basis the Plan President, which reviews benefits and claim issues as the third level of the appeals and grievance review process.

Exclusions and Limitations are the provisions of the Dental Services Group Subscriber Agreement for which coverage for a specific hazard or condition is entirely eliminated or restricted.

Facility is any building, premise or edifice in which dental care services or the administration of this Dental Plan is carried out.

Former Spouse for the purpose of Section 11.02 is defined as either an individual who is divorced from an employee or former employee or an individual who was married to an employee or former employee at the time of death of the employee or former employee.

Grievance is a Member complaint that alleges a Quality of Care issue.

Group is the single employer, or labor union trust or association with employer group participation identified on the Cover Sheet.

Medically Necessary services or supplies are Dental Services and supplies which are determined by PD to be:

a. Rendered for the treatment or diagnosis of an injury or disease;
b. Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with generally accepted dental practice and professionally recognized standards;
c. Not furnished primarily for the convenience of the Member, the attending Dentist or other provider of service; and
d. Furnished at the most appropriate level that may be provided safely and effectively to the Member.

Member is any Subscriber or Dependent.

Member Service Department is the person or persons designated by PD to whom oral and written Member complaints may be addressed. The Member Service Department may be contacted by telephone at 1-800-228-3384, or by writing to Member Service Department, PacifiCare Dental, 2099 S. State College Blvd. Ste. 500, Anaheim, California 92806.

Non-Participating Providers are licensed dentists and other licensed health care personnel that may provide services to Members enrolled in this Dental Plan but do not have written agreements with PD and are outside of the PD dental delivery network.

Open Enrollment Period is the period agreed upon by PD and Group during which all eligible Group employees and their eligible Dependents may enroll in this Dental Plan.

Out-of-Area is the geographic location anywhere outside of the Service Area in which PD is licensed to manage Dental Services in the State of California by the California Department of Managed Health Care.

Participating Provider is any individual practice association, individual primary care dentist or group of licensed dentists which has entered into a written agreement with PD to provide dental services to Member and which Member has selected from a list supplied by PD to provide or coordinate the provision of Member's Dental Services.

Peer Review Committee is a subcommittee of the Quality Assurance Committee composed of licensed dental professionals which meets monthly, or more frequently if necessary, to review quality of care complaints.

Plan is PacifiCare Dental.

Prevailing Rates are the usual, reasonable and customary rates for a particular dental care service in the Service Area as determined by PD.

Primary Residence is the home or address at which the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (i) Member moves without intent to return; (ii) Member is absent from the residence for 90 consecutive days; or (iii) Member is absent from the residence for more than 100 days in any six month period. Member shall notify PD of a change in Primary Residence as soon as possible. A change in Primary Residence shall result in disenrollment of the Member if Member's Primary Residence is not within the Service Area.

Primary Workplace is the facility or location at which the Member works most of the time, and to which the Member regularly commutes. If the Member does not regularly commute to one location then the Member does not have a Primary Workplace.

Providers are duly-licensed dentists or Specialists.

Quality Assurance Committee is a committee established and maintained by PD, consisting of at least three (3) dentist members from participating dental groups/IPA/Dentist, which approves PD policies and procedures and oversees actions of the PD Peer Review Committee or designated subcommittees.

Second Dental Opinion is an examination by an appropriately qualified health professional documented by a consultation report. A Member, or his or her treating participating health professional, may submit a request for a second dental opinion to PD. Second dental opinions will be provided when requested. If the Member is requesting a second dental opinion about care received from his or her Assigned Dental Office, the second dental opinion will be provided by an appropriately qualified health care professional within the PD participating provider network, whenever possible. If the Member is requesting a second dental opinion about care received from a specialist, the second dental opinion will be provided by a specialist within the PD participating provider network of the same or equivalent specialty, whenever possible.

Service Area is the geographic area in which PD is licensed to manage Dental Services in the State of California by the California Department of Managed Health Care.

Specialist is a dentist who, with additional training, has met specialty board requirements for eligibility and/or certification. The services of a dental Specialist include services in: endodontics, periodontics, oral surgery, pedodontics or any other specialized dental care.

Spouse is the Subscriber's legally recognized husband or wife under the laws of the State of California or domestic partner.

Subscriber is an individual who is enrolled in the Dental Plan pursuant to paragraph 2, for whom the appropriate Dental Plan Premium has been received by PD, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Totally Disabled means:

a. For Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness.
b. For Dependents, the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical impairment resulting from an injury or illness.

2. ELIGIBILITY AND ENROLLMENT

2.01 Enrollment Procedure. PD will arrange for Dental Services to Members who meet the eligibility requirements stated in this Agreement and who are properly enrolled in the Dental Plan pursuant to this Agreement. PD shall enroll such eligible Members up to PD's capacity, in the order in which they apply.

2.01.01 Application Form. A properly completed application for enrollment on a form provided by PD must be submitted to PD by the Group for each Subscriber, on behalf of the Subscriber and any Dependents. PD may, in its discretion and subject to specific protocols, accept enrollment through an electronic submission from the Group.

2.01.02 Time of Enrollment. All applications for enrollment shall be submitted by the applicant to the Group during open enrollment periods, except that Group employees and their eligible Dependents who were not eligible during the previous open enrollment period may apply for enrollment within thirty-one (31) days after becoming eligible. All applications for enrollment which are not timely received as described in section 2.01.1 by the Group shall be subject to rejection by PD. The Group shall provide notice to Members of the applicable open enrollment periods.

2.02 Subscriber Eligibility. Only Subscribers who meet the eligibility requirements stated in this Agreement may be enrolled in the Dental Plan. Loss of eligibility shall terminate a Subscriber's membership in this Dental Plan. A Subscriber must meet each of the following eligibility requirements:

a. Subscriber must permanently reside within the Service Area.
b. Subscriber must meet any eligibility requirements of the Group for membership in this Dental Plan.
c. Subscriber must designate a Participating Dentist within a 30-mile radius of Subscriber's residence as the primary provider of care to the Subscriber and his or her enrolled Dependents.

2.03 Dependent Eligibility. The Subscriber's Spouse and the unmarried dependent children of the Subscriber and Subscriber's Spouse. Children who are under the limiting age set forth on the Cover Sheet may enroll as Dependents of the Subscriber if the

Dependent meets each of the eligibility requirements set forth below. It is the Subscriber's responsibility to keep PD advised of changes in Dependent status due to age.

For purposes of eligibility, children of the Subscriber include:

(1) The natural born, children placed for the purposes of adoption or legally adopted children of the Subscriber or Subscriber's Spouse (i.e., stepchildren);
(2) Children for whom the Subscriber or Subscriber's Spouse has been appointed a legal guardian by a court;
(3) Children for whom the Subscriber or Subscriber's Spouse is required to provide dental coverage pursuant to a qualified medical child support order;

The following requirements must be met to ensure eligibility:

(1) The Subscriber through whom the Dependent is eligible must be enrolled in the Dental Plan.
(2) The Dependent must select a Participating Dental Group or Dentist located within a 30-mile radius of the Dependent's Primary Residence or Primary Workplace, if located within the PacifiCare Service Area, or within a 30-mile radius of the enrolled parent's Primary Residence or Primary Workplace.

Dependent enrollment and eligibility shall not be denied because the Dependent:

(1) Was born to a single person or unmarried couple.
(2) Is not claimed as a Dependent on the Subscriber's federal income tax return.
(3) Does not reside with the Subscriber or within the PD Service Area

To obtain coverage, all care must be provided or arranged in the Service Area by the designated Participating Dental Group or Dentist, as selected by the custodial parent or person having legal custody, except for Emergency and Urgent Services.

Information including, but not limited to, the identification card, combined evidence of coverage and disclosure form, or other available information, including notice of termination, will be provided to the custodial parent upon request.

2.03.01 Coverage for Students. A Dependent unmarried child who is registered on a full-time basis (at least twelve (12) semester units or the equivalent as determined by PD) at a certified educational institution may continue as an eligible Dependent to the limiting age of 25, provided proof of such status is submitted to PD on a periodic basis, as requested by PD. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Service Area with the Subscriber and the student must select a Participating Provider within a 30-mile radius of that address. To obtain coverage, all care must be provided or arranged in the Service Area by the designated Participating Provider except for Emergency Services.

2.03.02 Commencement of Coverage for Dependents. Coverage for newborn children of Subscriber or Subscriber's Spouse begins at birth. Coverage for children for whom the Subscriber or Subscriber's Spouse has been appointed legal guardian by a court begins on the date physical custody of the child is obtained by the legal guardian. PD may require the legal guardian to present evidence that physical custody has been obtained. Coverage for adopted children or children placed for adoption with the Subscriber or Subscriber's Spouse begins from and after the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release form, a medical authorization form, or a relinquishment form, granting the Subscriber or Subscriber's Spouse the right to control the health care of the adoptive child, or in the absence of a written document, on the date there exists evidence of the Subscriber's or Subscriber's Spouse's right to control the health care of the child placed for adoption.

In order for a newborn child to continue for more than thirty-one (31) days after birth or, in the case of an adopted child, thirty-one (31) days after the date physical custody is obtained, an enrollment form for the Dependent must be submitted to Group prior to the expiration of the thirty-one (31) days. Eligibility for a child for whom Subscriber has been appointed legal guardian ends when the guardianship ends or the child reaches the limiting age.

An application to enroll Dependents who become Dependents as a result of marriage to a Subscriber must be made within thirty-one (31) days of the date of marriage.

2.03.03 Coverage for Disabled Dependents. Dependent unmarried children, who reside within the Service Area with either the Subscriber or the Subscriber's separated or divorced spouse, who are incapable of self-sustaining employment by reason of mental retardation, debilitating Chronic condition, or physical handicap, and who are dependent upon the Subscriber for support and maintenance, and who would otherwise be eligible to enroll as Dependents except for the fact they are older than the limiting age, may enroll or continue enrollment in this Dental Plan beyond the limiting age, provided proof of such incapacity and dependency is provided to PD within thirty-one (31) days of the onset of the disability, attainment of the limiting age, or during an Open Enrollment Period. PD may require ongoing proof of Dependent's incapacity and dependency, but not more frequently than annually following the first two years following the attainment of the limiting age or the onset of the disability. Such proof shall include a written statement by a licensed psychologist, psychiatrist, or other physician to the effect that such Dependent is incapable of self-sustaining employment by reason of mental retardation, chronic condition or physical handicap.

2.03.04 Coverage for Dependents as a Result of Court or Administrative Order. A custodial parent who is not a PD Member or a legal custodian who is not a PD Member may inquire about Dependent coverage if the Subscriber is required to provide coverage for the Dependent pursuant to a court or administrative order, including a Qualified Medical Child Support Order (QMCSO). Information including, but not limited to, the identification card, combined disclosure/evidence of coverage form, or other available information, including notice of termination, will be provided to the custodial parent, legal custodian and/or District Attorney as requested. Coverage will begin on the first of the month following receipt by PD of an enrollment form with a copy of the court or administrative order.

2.04 Commencement of Coverage. The commencement date of coverage under this Dental Plan shall be the date of PD's acceptance of a Member's enrollment application and verification of a Member's eligibility in accordance with the terms of the Cover Sheet and this Agreement. PD's acceptance of a Member's enrollment application is contingent upon receipt of the applicable Dental Plan Premium payment.

2.05 Member's Eligibility Not Affected by Dental Status. A Member otherwise eligible and duly enrolled hereunder shall not be terminated from this Dental Plan due to the Member's dental status or need for dental services.

2.06 PD's Liability in the Event of Conversion From a Prior Carrier. In the event PD replaces a prior carrier of group dental benefits within sixty (60) days from the date of discontinuance of the prior group contract, PD shall immediately provide coverage to those persons who were validly covered under the previous contract and who are eligible for coverage under this Agreement. Such coverage shall not be limited by any Group requirements for coverage under this Agreement relating to active full-time employment, hospital confinement or pregnancy. Notwithstanding the above, PD shall not be financially responsible for benefits or services provided to persons who are Totally Disabled at the date of discontinuance of the prior coverage and entitled to an extension of benefits from the prior carrier under California Health and Safety Code Section 1399.62 or Insurance Code Section 10128.2 to the extent the benefits or services are directly related to any conditions which caused the total disability.

3. GROUP OBLIGATIONS, DENTAL PLAN PREMIUMS AND COPAYMENTS

3.01 Non-Discrimination. The Group shall offer PD an opportunity to market this Dental Plan to its employees and shall offer its employees an opportunity to enroll in this Dental Plan under no less favorable terms or conditions than group offers enrollment in other Specialized Health Care Service Plans or Employee Health Benefit Plans.

3.02 Notices to PD. The Group shall forward to PD all completed or amended enrollment forms to PD within thirty-one (31) days of the Member's initial eligibility. The Group acknowledges that any enrollment applications not forwarded to PD within thirty-one (31) days may be rejected by PD.

The Group shall forward all notices of termination to PD within thirty-one (31) days after the Member loses eligibility or elects to terminate membership under this Agreement. The Group shall be responsible for any Member Dental Plan Premiums through the last day of the month in which notice of termination is received by PD based upon the date notification is received by PD (e.g., if member terminates from the 1st through the 15th, no premium payment will be due; if the member terminates from the 16th through the 31st, full premium payment will be due).

3.03 Notices to Member. If The Group or PD terminates this Agreement pursuant to Section 9 herein, the Group shall promptly notify all Members enrolled through the Group of the termination of their membership in this Dental Plan. The Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of termination sent from PD to the Group at the Subscriber's current address. The Group shall promptly provide PD a copy of the notice of termination delivered to each Subscriber, along with evidence of the date the notice was provided. If, pursuant to Paragraphs 3.07.01 and 3.07.02 herein, PD increases Dental Plan Premiums payable by the Subscriber, increases Copayments, or reduces Covered Services provided under this Agreement, the Group shall promptly notify all Members enrolled through the Group of the increase or reduction. The Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of the Health Plan Premium or Copayment increase or reduction in Covered Services sent from PD to the Group at the Subscriber's then current address. The Group shall promptly provide PD with a copy of the notice of Health Plan Premium or Copayment increase or reduction in Covered Services delivered to each Subscriber, along with evidence of the date the notice was provided. PD shall have no responsibility to notify Members in the event the Group fails to provide the notices required by this paragraph 3.03.

3.04 Indemnification. The Group agrees to indemnify, defend and hold PD harmless and accept all legal and financial responsibility for any liability arising out of the Group's failure to perform its obligations as set forth in this Section 3.

3.05 Rates. The Dental Plan Premium rates are set forth in the Dental Plan Premiums section of the Cover Sheet and supplemental Dental Plan Premium notices.

3.06 Due Date. Dental Plan Premiums are due in full on a monthly basis and must be paid directly by the Group to PD on or before the 20th day of the month prior to the month in which coverage commences. PD reserves the right to assess an administrative fee of **five (5)** percent of the monthly premium prorated on a 30-day month for each day it is delinquent thereafter. This fee will be assessed solely at PD's discretion.

3.07 Modification of Rates and Benefits.

3.07.01 Modification of Dental Plan Premium Rates. The Dental Plan Premium rate set forth in Exhibit E of this Agreement and the PD enrollment packet and the benefits set forth in Exhibits A and B of this Agreement and in the PD enrollment packet may be modified by PD in its sole discretion upon thirty (30) days written

notice mailed postage prepaid to the Group. Any such modification shall take effect commencing the first full month following the expiration of the 30-day notice period, which commences upon the Group's receipt of the notification.

Notwithstanding the above, if the State of California or any other taxing authority imposes upon PD a tax or license fee which is levied upon or measured by the monthly amount of Dental Plan Premiums or by PD's gross receipts or any portions of either, then upon thirty (30) days written notice to the Group which commences upon the Group's receipt of the notification, the Group shall remit to PD with the appropriate payment, a pro rata amount sufficient to cover all such taxes and license fees rounded to the nearest cent.

3.07.02 Modification of Benefits or Terms. The Covered Services set forth in Exhibits A and B of this Agreement and in the PD enrollment packet, as well as other terms of this Agreement, may be modified by PD in its sole discretion upon thirty (30) days written notice mailed postage prepaid to the Group. Any such modification shall take effect commencing the first full month following the expiration of the 30-day notice period, which commences upon the Group's receipt of the notification.

3.08 Payments Made in Error. Should PD pay any fees for services which were not authorized by a Member's Primary Care Dentist or which were not Emergency Services, the Member shall reimburse PD for such payment. Failure to reimburse PD or reach reasonable accommodations with PD concerning repayment within thirty (30) days after PD's request for reimbursement shall be grounds for termination of a Member's membership pursuant to paragraph 10.01.01 of this Agreement. The exercise of PD's right to terminate this Agreement shall not affect its right to continue enforcement of its right to reimbursement from the Member.

3.09 Effect of Payment. Except as otherwise provided in this Agreement, only Members for whom Dental Plan Premiums are received by PD are entitled to dental care benefits as described in this Agreement, and then only for the period for which such payment is received. Subscribers will be billed for coverage for the first month of coverage for newborn or adopted children eligible as provided in Paragraph 2.03.

4. BENEFITS AND CONDITIONS FOR COVERAGE

4.01 Member Obligations. A Member shall complete and submit to PD an enrollment application or other forms or statements as PD may reasonably request. A Member agrees to promptly notify PD or the Group of any changes in the information contained in the enrollment application packet. The Member warrants that to the best of his or her knowledge, all information contained in such application, forms and statements is true and complete, and agrees that all rights to benefits under this Agreement are subject to the condition that all such information is true and complete.

4.02 Benefits. Subject to all terms, conditions, exclusions, and limitations set forth in this Agreement, all eligible Members, upon receipt by PD of all applicable monthly Dental Plan Premium payments, shall be entitled to the dental services and benefits described in this Agreement.

4.03 Use of Participating Dental Group/IPA/Dentist for Medically Necessary Services. Except as otherwise specifically provided in this Dental Plan, all services which are provided under this Dental Plan must be Medically Necessary and provided or arranged by Member's designated Participating Dental Group/IPA/Dentist. Except for Emergency Services, neither PD nor any Participating Dental Group/IPA/Dentist shall have any liability or obligation for any service or benefit sought or received by any Member from an Non-Participating Provider, unless prior special arrangements are made by the Member's Participating Dental Group/IPA/Dentist and authorized by PD.

4.04 Identification Cards. Identification cards issued by PD to a Member are for identification purposes only. Possession of an identification card confers no right to services or other benefits under this Dental Plan. The holder of an identification card must be a Member on whose behalf all applicable Dental Plan Premium, Copayments and other charges have been received by PD. Any person receiving benefits or services for which he or she is not entitled shall be charged for such benefits or services at Prevailing Rates. If any Member permits the use of this identification card by any other person, PD may immediately terminate such Member's membership.

4.05 Copayments. Copayments, when applicable, are an obligation of the Member at the time services are rendered. Failure to pay a Copayment may result in termination of Member's coverage under this Dental Plan. A schedule of the applicable Copayments for services rendered to Member is set forth in the Schedule of Benefits, incorporated herein and attached hereto as Attachment A.

4.06 Selection of Participating Dental Group/IPA/Dentist. Along with the Enrollment Form, each member will receive a directory of Participating Dental Group/IPA/Dentist. Each Member must designate a Participating Dental Group/IPA/Dentist located within a 30-mile radius of the Member's Primary Residence or Primary Workplace on the Enrollment Form when applying for enrollment in this Dental Plan. Failure to designate a Participating Dental Group/IPA/Dentist will result in PD selecting a Participating Dental Group/IPA/Dentist on Member's behalf.

The Member and his/her Dependents must all go to the same selected Participating Dental Group/IPA/Dentist unless otherwise agreed upon by PD. If the Participating Dental Group/IPA/Dentist that the Member chooses is no longer available, PD will re-assign the Member to the next nearest office available. If no selection is made at the time of enrollment, PD will assign the Member to the nearest office. In the event that a Member is dissatisfied with any Participating Dental Group/IPA/Dentist for any reason, and desires to transfer to another Participating Dental Group/IPA/Dentist, the Member may do so by contacting PD at the telephone numbers listed herein, and may transfer to

another Participating Dental Group/IPA/Dentist. If PD is notified by the 20th of the month, the transfer will be effective the first day of the next month.

4.06.01 Change of Participating Dental Group/IPA/Dentist. A Member may change a Participating Dental Group or participating primary care dentist by calling PD's Member Service Department or obtaining a Change Request Form from a Member Service Representative. A Member must select a Participating Dental Group/IPA/Dentist located within a 30-mile radius of the Member's residence or Primary Workplace. If the request is received before the 20th of the month, PD will change the Member's Participating Dental Group or participating primary dentist effective the first day of the following month. If PD receives the Member's request after the 20th of the month, the change will be effective the first day of the second month following the request to change a Participating Dental Group or participating primary dentist.

4.06.02 Required Change of Participating Dental Group/IPA/Dentist. A Member acknowledges and agrees that PD, in its discretion, and upon request by the Participating Dental Group/IPA/Dentist, due to a material detrimental change in the Participating Dental Group/Member relationship, has the right to transfer a Member to another specified Participating Dental Group or participating Provider, if necessary and Member is medically able.

PD shall notify the Member of any termination or breach of contract by, or inability to perform by a Member's Participating Dental Group/IPA/Dentist, within thirty (30) days of such termination, breach, or inability to perform. In such event, the Member may continue to receive care from the Participating Dental Group/IPA/Dentist until PD has made reasonable provision for the assumption of services by another contracting provider and notified the Member of such.

All PD requests to a Member pursuant to this Section 4.06.02 to designate a new Participating Dental Group/IPA/Dentist shall provide the Member with thirty-one (31) days within which to select another Participating Dental Group/IPA/Dentist. A Member's failure to designate a new Participating Dental Group/IPA/Dentist within thirty-one (31) days shall constitute a waiver of Member's right under this Agreement to select his or her Participating Dental Group/IPA/Dentist.

In such instance, PD shall designate a Participating Dental Group/IPA/Dentist on the Member's behalf located within thirty (30) miles of Member's residence or Primary Workplace. PD shall send written notice of the identity and effective date of change of the Participating Dental Group/IPA/Dentist to the Member. A Member's failure or refusal to receive or obtain authorization for Medically Necessary treatment from that Member's primary dentist within such Participating Dental Group/IPA/Dentist may result in PD's denial of benefits for such treatment.

4.07 Refusal of Dental Treatment. A Member may refuse to accept a Participating Dental Group/IPA/Dentist's recommended treatment, counsel or procedures. The Participating Dental Group/IPA/Dentist may regard such refusal to accept its recommendations as incompatible with the continuance of the dentist-patient relationship and as obstructing the provision of proper dental care.

If a Member refuses to accept the recommended treatment, counsel or procedures, and the Participating Dental Group/IPA/Dentist believes no professionally acceptable alternatives exist, the Member shall be so advised. The Participating Dental Group/IPA/Dentist may request PD to change a Member to a different Participating Dental Group/IPA/Dentist if the dentist-patient relationship is materially damaged by the Member's refusal to accept recommended treatment, counsel or procedure.

PD will evaluate such request considering the Member's best interests and the geographic accessibility of another Participating Dental Group/IPA/Dentist. If PD grants the request for transfer, PD shall request the Member to select another Participating Dental Group/IPA/Dentist within thirty-one (31) days. If the Member fails to select another Participating Dental Group/IPA/Dentist, PD shall designate another Participating Dental Group/IPA/Dentist on the Member's behalf. If the Member continues to refuse to accept the Participating Dental Group/IPA/Dentist's recommended treatment, counsel or procedures and no professionally acceptable alternatives exist, neither PD nor the Participating Dental Group/IPA/Dentist shall be responsible to provide or arrange for dental care or pay for the condition under treatment.

4.08 Payment for Non-Covered Services. Nothing in this Agreement shall prevent PD or the Participating Dental Group/IPA/Dentist from collecting Prevailing Rates from the Member for non-covered services or for services rendered due to fraud or misrepresentation by a Member.

4.09 Emergency Services. The costs of Emergency Services, minus applicable Copayments, shall be covered by PD if the procedures discussed in Paragraph 4.09.01 are followed. Notwithstanding the above, if the need for any Covered Services arises while the Member is within the Service Area, such services must be provided or arranged by a Member's Participating Dental Group/IPA/Dentist unless the time required to contact the Member's Participating Dental Group/IPA/Dentist would create a delay in treatment which could cause a reasonable person to believe it could result in permanent physical impairment or loss of life to the Member.

4.09.01 Procedure for Receiving Emergency Services.

a. If possible, the Member, or someone acting on the Member's behalf should call the Member's Participating Dental Group/IPA/Dentist and follow the instructions provided.
b. If the Member requires Emergency Services for a dental condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, swelling or bleeding, such that the time required

to contact the Member's Participating Dental Group/IPA/Dentist could cause a reasonable person to believe that it could result in (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part, and which cannot be delayed until the Member returns to the Service Area, Member should go directly to the nearest dental facility for treatment.

c. If the Member is unable to contact his or her Participating Dental Group/IPA/Dentist prior to going to a dental facility for Emergency Services, the Member or someone acting on the Member's behalf must notify or take reasonable steps to notify the Member's Participating Dental Group/IPA/Dentist within twenty-four (24) hours or as soon as reasonably possible after the initial receipt of Emergency Dental Services to inform the Participating Dental Group/IPA/Dentist of the location, duration and nature of the Emergency Services provided.

d. If Covered Services are received from an Non-Participating Provider, the Member should first follow the procedures described in Section 4.09.01(a-c) above. Following the receipt of Emergency Services, the Member should notify the PD Member Service department in writing as soon as possible of the nature and necessity of the Emergency Services and should attach any bills Member has received. PD shall pay undisputed claims, minus applicable Copayments, within forty-five (45) working days of receipt of a properly completed claim.

5. LIMITATION ON BENEFITS

5.01 Acts Beyond PD's Control. In the event of circumstances not reasonably within the control of PD, of the Participating Dental Group/IPA/Dentist, such as any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, which results in the unavailability of the facilities or personnel, PD and the Participating Dental Group/IPA/Dentist shall provide or attempt to arrange for dental services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel. Neither PD nor any Participating Dental Group/IPA/Dentist shall have any liability or obligation for delay or failure to provide or arrange for dental services if such delay or failure is the result of any of the circumstances described above.

5.02 Specialty Referral. Costs and services secured from other dentists or dental Specialist other than Participating Dental Group/IPA/Dentist will not be paid to the Member or to the Non-Participating dentist or dental Specialist unless the services meet the criteria for Emergency Services.

The Member is responsible for any Copayments listed in the corresponding member materials. If, in the opinion of Participating Provider, Member must be referred to a Specialist, this will be done under the following conditions:

a. A referral tracking form is submitted to PD for a Specialty Referral by a Professional Provider prior to treatment.

b. When referral is made, it will always be made to a Plan Specialist unless one is not available, in which case Member may make own selection. The liability of the Plan shall be no more than the amount listed in Exhibit A, per family above the Member's Copayments for such specialty referral.

c. Pedodontic referrals apply to all children through age 18 as necessary. Member is responsible for 49% of pedodontist's contracted rate.

The Member will be responsible for balance due; payable on such terms and conditions as are arranged between the Member and the Specialist.

6. PARTIES AFFECTED BY THIS AGREEMENT; RELATIONSHIPS BETWEEN PARTIES

6.01 Member Non-Liability. In the event PD fails to pay a Participating Dental Group/IPA/Dentist for a service covered in Exhibit A which is provided to a Member, the Member shall not be liable to the Participating Dental Group/IPA/Dentist for any sums owed by PD.

6.02 Participating Dental Group/IPA/Dentists are Independent Contractors. The relationships between PD and its contracting Providers are independent contractor relationships. None of the contracting Providers or employees are employees or agents of PD, and neither PD nor any employee of PD is an employee or agent of any Participating Dental Group/IPA/Dentist.

6.03 Dentist-Patient Relationship. Except as provided in Paragraphs 4.06.01 and 4.07 of this Agreement, the Member is responsible for selecting his own Participating Dental Group/IPA/Dentist. The dentist-patient relationship between the Participating Dental Group/IPA/Dentist and Member shall be maintained by the Participating Dental Group/IPA/Dentist. The Participating Dental Group/IPA/Dentist is responsible to Member for the provision of all Dental Services rendered to Member by that Participating Dental Group/IPA/Dentist. The Member acknowledges that PD is a health maintenance organization and not a health care provider.

6.04 Relationship of Parties. The Group is not the agent or representative of PD, and shall not be liable for any acts or omissions of PD, its agents or employees, or Providers, or any other person or organization with which PD has made, or hereafter shall make, arrangements for the performance of services under this Dental Plan. The Member is not the agent or representative of PD, and shall not be liable for any acts or omissions of PD, its agents or employees.

7. MEMBER GRIEVANCE PROCEDURE, QUALITY REVIEW PROCESS AND ARBITRATION

7.01 Member Complaints Against PD. PD and the Member agree to the resolution of any and all complaints, grievances or appeals between PD and the Member, including, but not limited to, allegations by a Member against PD of medical malpractice and other disputes relating to the delivery of services under the Dental Plan, through the use of the PD Member Grievance Procedure, including the use of binding arbitration, and the Quality Review Process. The PD Grievance Procedure and Quality Review Process are designed to ensure that all Member complaints are handled promptly, investigated thoroughly and resolved in a timely manner. Complaints relating to claims payment or coverage decisions with which the Member is dissatisfied ("appeals") and all other grievances not related to quality of care are reviewed in accordance with the Grievance Procedure outlined in Section 7.01.01. Complaints relating to quality of care are reviewed in accordance with the Quality Review Process outlined in Section 7.01.02. If a single complaint involves both a quality of care issue and non-quality of care issues (i.e., a grievance or appeal), the quality of care complaint and the grievance or appeal will be reviewed separately and simultaneously under the applicable PD review procedure. Any complaint involving an imminent and serious threat to the dental health of a Member will be remanded immediately by the PD Chief Dental Officer for review under the Expedited Review Procedure outlined in Section 7.01.03.

Members can file a complaint, grievance or appeal with PD by calling the PD Member Services Department at 800-228-3384, by writing a letter to the PD Appeals Department at Post Office Box 899, Tustin, CA 92780, or by requesting a complaint form from the PD Member Services Department or any Participating Dental Provider and submitting the completed complaint form to the Member Services Department or Appeals Department or your Participating Dental Provider. PD will not discriminate against a Member on the grounds that the Member filed a grievance, appeal or quality of care complaint.

Member complaints are received either by telephone or in writing through the PD Member Services Department or Appeals Department. Complaints received by the Member Service Department which are unable to be resolved to the Member's satisfaction by the Member Service Department are sent to the Appeals Department for evaluation. If the complaint is received by telephone and the person taking the call is unable to resolve the problem to the satisfaction of the Member, the Member will be asked to submit the complaint in writing to initiate the formal grievance procedure. A Clinical Information Coordinator will assist the Member in filing a written complaint if the Member so desires. Within three (3) business days of receipt by the Appeals & Grievance Department the Member will be sent a written acknowledgment card indicating PD's receipt of the complaint and a contact phone number for any questions. The Member will receive a written resolution of the complaint within 30 days of PD's initial receipt of the complaint.

All unresolved complaints are directed to the PD Clinical Information Coordinator. The Clinical Information Coordinator conducts an initial review within one (1) business day and attempts to resolve the complaint. If the complaint involves a request for payment of a claim or coverage of a service or other non-quality of care issue and cannot be resolved, the Clinical Information Coordinator will process the complaint under the Grievance

Procedure described in Section 7.01.01 below. All quality of care complaints are referred to the Quality Management Department for review under the Quality Review Process described in Section 7.01.02 below.

7.01.01 PD Appeals Procedure. The following procedures will be followed in handling Member complaints involving claims payment or benefit determinations with which Member is dissatisfied or other issues not related to quality of care. Each level of review under the Appeals Procedure will be conducted independently and at no time will a person who has been involved in a determinate made at one level be involved as a decision-maker in a review of that determination. At the conclusion of each level of review, the reviewers shall file a written report in the Member's appeals file indicating the information which has been reviewed and the findings and conclusions of the reviewer.

a. Within thirty (30) days of receipt of a appeal, PD's Clinical Information Coordinators shall conduct a review (consulting other appropriate PD departments or personnel, if necessary) and make an initial determination as to the resolution of the appeal and shall send the written initial determination to the Member.

b. If the Member is dissatisfied with the initial determination by the Clinical Information Coordinators, the Member may request a review by the Benefits Review Committee by submitting a written request. The Benefits Review Committee shall review the Member's complaint and provide a written determination to the Member within thirty (30) days from the date of receipt of the request for review. A meeting of the Benefits Review Committee shall be scheduled within thirty (30) days of the Member's request for review by the Benefits Review Committee. The Member may submit written information or material relating to the grievance or appeal to the Benefits Review Committee for review.

c. If the complaint is not resolved to the Member's satisfaction by the Benefits Review Committee, the Member may request a redetermination. If the complaint involves an issue which requires dental care decision making, such as a clinical issue, the necessity for treatment or the appropriate type of treatment, the complaint will be reviewed by the PD Chief Dental Officer (or dental consultant(s) designated by the Chief Dental Officer) who was not involved in the initial determination. If the complaint involves an issue which does not require medical decision making, it will be reviewed by a PacifiCare executive officer A written redetermination shall be made by the PD Executive Review Committee/Dental Director and shall be sent to the Member within thirty (30) days of receipt of the request for the review.

d. If the Member is dissatisfied with the redetermination the Member may submit or request that PD submit the appeal to voluntary mediation or binding arbitration, before the American Arbitration Association.

i. Voluntary Mediation - In order to initiate mediation, the Member or the agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by the American Arbitration Association in accordance with its Commercial Mediation Rules, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

ii. Binding Arbitration- Pursuant to California law any claim of up to $200,000 must be decided by a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than $200,000. However, PD and the Member may agree in writing to waive the requirement to use a single arbitrator and instead use a tripartite arbitration panel that includes the two party appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties. The Member shall have three business days to rescind the waiver agreement unless the agreement has also been signed by the Member's attorney, in which case the waiver cannot be rescinded. In cases of extreme hardship PD may assume all or part of a Member's share of the fees and expenses of the neutral arbitrator provide the Member has submitted a hardship application with the American Arbitration Association. The approval or denial of a hardship application shall be determined by the American Arbitration Association. A Member may obtain a hardship application by contacting the American Arbitration Association in Los Angeles at (213) 383-6516, in Orange County at (714) 474-5090, in San Diego at (619) 239-3051 and in San Francisco at (415) 981-3901. If a request for binding arbitration is not submitted within sixty (60) days, the redetermination will be final and binding. However, Members who have legitimate health or other reasons which would prevent them from electing binding arbitration within sixty (60) days will have as long as is necessary to accommodate their special needs in order to elect

binding arbitration. Further, Members who seek review by the Department of Managed Health Care within sixty (60) days of the redetermination will have an additional sixty (60) days from the date of the final resolution of the matter by the Department of Managed Health Care to elect binding arbitration.

Upon submission of a dispute to the American Arbitration Association, the Member and PD agree to be bound by the rules of procedure and decision of the American Arbitration Association. The provisions of Code of Civil Procedure Section 1283.05, permitting the taking of depositions and the obtaining of discovery, shall be incorporated into and made applicable to this agreement.

PD AND MEMBER UNDERSTAND THAT BY ENTERING INTOTHIS AGREEMENT, THEY ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

7.01.02. Grievance Review Process.

a. All quality of care complaints initially received are forwarded to the Appeals and GrievanceDepartment for investigation, review and determination of any appropriate action. Quality of care complaints that affect a Member's current treatment shall be immediately evaluated. Quality of Care complaints are reviewed initially by the Clinical Information Coordinators.
b. Within three (3) business days of receipt by the Appeals & Grievance Department the Member will be sent a written acknowledgment card indicating PD's receipt of the complaint and a contact phone number for any questions. The Member will receive a written resolution of the complaint within 30 days of PD's initial receipt of the complaint.
c. The Chief Dental Officer or his licensed designee will be responsible for responding to questions the Member may have about his or her complaint and about the Grievance Review Process. Where appropriate, the Chief Dental Officer may arrange a meeting between the Member and a Participating Dental Group/IPA/Dentist or administrator.
d. The relevant dental records are obtained from the appropriate providers and are reviewed by the PD Chief Dental Officer or licensed designee.
e. If necessary, a letter is sent to the Participating Dental Group/IPA/Dentist, as appropriate, requesting further information.

Additional information is received and reviewed by the Chief Dental Officer or licensed designee.

f. After obtaining the dental records and consulting with the dental consultants, the Clinical Information Coordinators assign the case a code number indicating the severity of any quality problems identified.
g. The case is referred to the PD Chief Dental Officer/Dental Consultant, whichever has not previously reviewed the case, for review and recommendation of any appropriate corrective action deemed necessary against the Participating Dental Group/IPA/Dentist involved.
h. The Member shall be notified in writing upon completion of the Grievance Process, which shall be within thirty (30) days of receipt of the quality of care complaint. However, it may not be reasonably possible to complete the Grievance Process within thirty (30) days due to circumstances beyond the control of PD (such as, PD is awaiting records and additional information requested from the Participating Dentist involved, the Member or other providers). In such event, the Member will be so notified within the original thirty (30) days and will be promptly notified in writing as soon as the Grievance Process is completed.
i. The written notice of the completion of the Grievance Process will generally inform the Member that PD has taken appropriate corrective action, as warranted, to address the Member's quality of care complaint. However, the oral and written communications of the participants in the Grievance Process and the results of the quality review shall remain confidential as required by law. Quality of care complaints are not subject to review under the Appeals Procedure or arbitration.
j. The Chief Dental Officer or his or her designee shall follow-up to ensure that any corrective actions recommended against a Participating Dental Group/IPA/Dentist are carried out.

7.01.03 Expedited Review Process. Complaints involving an imminent and serious threat to the dental health of the Member, including, but not limited to, potential loss of life, limb, or major bodily function, will be immediately referred to the PD Chief Dental Officer for expedited review, regardless of whether such complaints are received orally or in writing. If a complaint has been sent to the Chief PD Dental Officer for immediate expedited review, PD will immediately inform the Member in writing of his or her right to notify the Department of Managed Health Care of the emergency grievance. The PD Chief Dental Officer will complete the expedited review and make a determination on the complaint, and will provide the Member and the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review, within a time period appropriate to the clinical urgency of the situation, but no later than three (3) days from receipt of the complaint. A Member may request

redetermination by contacting the Member Appeals & Grievance Department, either orally, or in writing.

7.02 Review by Commissioner of the Department of Managed Health Care. The Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number (1-888-HMO-2219) to receive complaints regarding health plans. The hearing and speech impaired may call the department's direct toll free number (1-877-688-9891) or the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)). The department's facsimile number is 1-916-229-4328.The department's Internet website (http://www.hmohelp.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan PacifiCare Dental at (1-800-228-3384) and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

a. The Member may submit an unresolved complaint to the Department for review after either completing the PD Grievance Procedure described in Section 7.01 above, or participating in such procedure for at least thirty (30) days. In any case determined by the Department to be a case involving an imminent and serious threat to the health of the Member, or in any other case where the Department determines that an earlier review is warranted, a Member shall not be required to complete or participate in the PD Grievance Procedure for thirty (30) days prior to review by the Department.
b. The Member, or a person acting on behalf of the Member, may also request voluntary mediation with PD with respect to a complaint, other than a quality of care complaint, prior to exercising the right to submit a complaint to the Department. In order to initiate mediation, the Member, or the Member's agent, and PD must voluntarily agree to mediation. Expenses for any mediation shall be borne equally by Member and PD.

7.03 Member Claims Against Participating Dental Group/IPA/Dentists. Member claims for benefits under this Agreement shall be reviewed under the PD Grievance Procedure described in Section 7.01 above. Member claims against a Participating Dental Group/IPA/Dentists other than claims for benefits under this Agreement, including, but not limited to, claims by Member against a Participating Dental Group/IPA/Dentists for medical malpractice, are not governed by this Agreement. Members may seek any

appropriate legal action against the Participating Dental Group/IPA/Dentists for such claims as deemed necessary. Member claims against a Participating Dental Group/IPA/Dentists arising from the delivery of services for benefits (timeliness of referrals and appointments, etc.) are governed by this agreement.

In the event of a dispute or claim between a Member and any Participating Dental Group/IPA/Dentists for claims, other than claims for benefits under this Agreement, and upon mutual agreement between Member and the Participating Dental Group/IPA/Dentists, PD agrees to make available the PD Grievance Procedure described in Section 7.01 of this Agreement for resolution of such dispute. In such an instance, the decision of PD's Quality Assurance Committee shall not be binding upon the parties except upon agreement between the parties. Such disputes shall not be subject to binding arbitration except upon agreement between the parties. Should the Member and a Participating Dental Group/IPA/Dentists fail to resolve the dispute, the Member and Participating Dental Group/IPA/Dentists may seek any appropriate legal action deemed necessary.

All Member claims against PD, including, but not limited to, allegations by a Member against PD of medical malpractice and other disputes relating to the delivery of services under the Dental Plan, shall be resolved as discussed in Section 7.01. The existence of any disputes or claims between PD and any Participating Dental Group/IPA/Dentists, including, but not limited to, claims by a Member against a Participating Dental Group/IPA/Dentists for medical malpractice, shall in no way affect the obligation of the Member and PD to submit to binding arbitration for any and all disputes or claims between the Member and PD as provided in Section 7.01.

7.04 Disputes Between PD and Group. All disputes or claims between the Group and PD shall be resolved by binding arbitration before the American Arbitration Association. Upon submission of a dispute to the American Arbitration Association, the Group and PD agree to be bound by the rules of procedure and decision of the American Arbitration Association. The provisions of California Code of Civil Procedure Section 1283.05 and 1283.1, permitting the taking of depositions and the obtaining of discovery, shall be incorporated into and made applicable to this Agreement. The arbitrators shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the decision is based. The arbitrators shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California Code of Civil Procedure Sections 1286.2 or 1286.6 for any such error.

PD and the group understand that by entering into this agreement, they are each voluntarily giving up their constitutional right to have all disputes between PD and the group decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

8. TERM OF AGREEMENT: AUTOMATIC RENEWAL

The term of this Agreement shall be one (1) year commencing on the date of execution of this Agreement, unless otherwise indicated on the Cover Sheet or unless this Agreement is terminated as provided herein. This Agreement shall automatically renew for a one (1) year term on each anniversary of the date of commencement of this Agreement, or as indicated on the Cover Sheet, unless terminated as provided herein.

9. TERMINATION OF GROUP COVERAGE

9.01 Termination by the Group. The Group may terminate this Agreement by giving a minimum of thirty (30) days written notice of termination to PD. The Group shall continue to be liable for Dental Plan Premiums for all Members enrolled in this Dental Plan until the date of termination.

9.02 Termination by PD.

9.02.01 For Nonpayment of Dental Plan Premium. PD may terminate this Agreement in the event the Group or its designee fails to remit Dental Plan Premiums by the required date to PD by giving written notice of termination of this Agreement via First Class Mail to the Group. Nonpayment of Dental Plan Premiums includes payments returned due to non-sufficient funds (NSF) and post dated checks. Such notice shall specify that payment of all unpaid Dental Plan Premiums must be received by PD within fifteen (15) days of the date notification is received by the Subscriber, and if payment is not received within the fifteen (15) day period, no further notice shall be given and coverage for all Members enrolled in this Dental Plan shall terminate effective at the end of the month for which Dental Plan Premiums have been actually received by PD. Reinstatement of this Agreement may occur, at PD's discretion, only by execution of a new Dental Service Group Subscriber Agreement and by submitting a new application for enrollment for each Member in accordance with the current eligibility and enrollment requirements. The Group shall be required to submit a deposit in the amount of one full month's premium, to PD to be held on account. This deposit will be returned to the Group upon completion of twelve (12) consecutive months of timely Dental Plan Premiums payment, or upon earlier termination of the Agreement, provided that all premium payments have been met at the time of termination. In the event the Group defaults on its premium payments within the first twelve months, PD will apply the deposit toward the satisfaction of the premium obligation and will return to the Group only that portion of the deposit, if any, that remains after the obligation has been satisfied.

9.02.02 For Breach of Material Term. PD may terminate this Agreement if the Group materially breaches any material term, covenant or condition of this Agreement, and fails to cure such breach within sixty (60) days of receiving written notice of such breach from PD. PD's written notice of breach shall make specific reference to the Group's action causing such breach. If the Group fails to cure its breach subject to PD's satisfaction within sixty (60) days of receiving

notice of the breach from PD, PD may terminate the Agreement at the end of the sixty (60) day notice period.

9.02.03 For Providing Misleading or Fraudulent Information. PD may terminate this Agreement upon thirty (30) days written notice to the Group if the Group knowingly provides materially misleading or fraudulent information to PD in any group questionnaires or is aware that materially misleading or fraudulent information has been provided on membership enrollment forms.

9.02.04 For Ceasing to Meet Eligibility Criteria PD may terminate a Group upon thirty (30) days written notice to the Group if the Group fails to meet any of the following Group eligibility requirements:

a) The Group fails to maintain a Group Participation percentage of 75%;
b) For Subscribers without Dependents, the Group fails to maintain a Group Contribution equal to 75% of the Dental Plan Premiums;
c) For Subscribers with Dependents, the Group fails to maintain a Group Contribution equal to the dollar amount of the Group Contribution for Subscribers without Dependents;
d) The Group fails to abide by and enforce the conditions of the Subscriber enrollment set forth in Paragraph 2.01 of this Agreement.

9.02.05 For Changing the Nature of Group's Business. PD may terminate a Group upon thirty (30) days written notice to the Group if the Group materially alters the nature of its business. "Materially Alters," for the purposes of this Section 9.02.05, means a significant change in the business conducted by Group after the Commencement of the Agreement as determined by PD.

9.02.06 For Loss of Group's Office Location Within Geographic Area of Licenser. PD may terminate a Group if the Group no longer maintains an office location within the area in which PD is licensed as a health care service plan. PD shall provide the Group with thirty (30) days written notice prior to such termination, if possible.

9.03 Proration of Dental Plan Premiums. If a Group submits partial month's premium for the final coverage month, PD shall have the discretion to cancel the Group coverage at the end of the previous month and refund the partial payment or cancel the Group coverage at the end of the final month and pursue collection of the outstanding premium.

10. TERMINATION OF MEMBERSHIP

10.01 Termination. The rights of Members under this Agreement shall terminate upon occurrence of any of the following:

10.01.01 Nonpayment of Dental Plan Premiums or Copayments. Any Member for whom applicable Dental Plan Premium payments or Copayments are not paid

may be disenrolled from this Dental Plan by PD within fifteen (15) days after receipt of written notice of termination via First Class Mail for nonpayment by such Member. Such notice shall state that the receipt by PD of the applicable Dental Plan Premium or Copayments within fifteen (15) days shall cause PD to revoke the notice.

The failure of any Member to reimburse PD for payments made in error by PD within fifteen (15) days of receipt by Member of written notice of termination for nonpayment by PD or to reach reasonable accommodations with PD regarding repayment shall result in the termination of Member's membership in this Dental Plan. To reinstate coverage, the Member must submit a new application for membership and comply with all applicable eligibility requirements.

10.01.02 Termination of Agreement by the Group. In the event Group voluntarily terminates this Agreement pursuant to Subparagraph 9.01 of this Agreement, the Member's membership in this Dental Plan shall terminate at the end of the month for which the last Dental Plan Premium is received by PD from Group on Member's behalf.

10.01.03 Member Moves Out of Service Area. A Member's enrollment in this Dental Plan shall terminate if the Member changes his or her Primary Residence or Primary Workplace to a location outside the Service Area. Termination shall be effective the last day of the month in which Member receives notice of termination from PD. Notice sent to the Member's last-known address shall be deemed effective notice for purposes of this Section 10.01.03.

10.01.04 Member's Loss of Eligibility. In the event a Member loses his or her eligibility for membership in this Dental Plan, the Member's membership in this Dental Plan shall terminate on the last day of the month in which the Member's eligibility ceases. The Member shall be eligible for continuing benefits as set forth in Section 11.

a. Person Never Eligible for Membership. In the event a person has never been eligible for membership in this Dental Plan, but has received the benefits of membership in this Dental Plan for reasons other than the fraud or deception of the person or another person through which the person is enrolled as a Dependent, such person's benefits shall be terminated effective fifteen (15) days after mailing by PD of a written notice of termination via First Class Mail.

b. Dissolution of Subscriber's Marriage, (Dependent Eligibility). In the event of dissolution of marriage, coverage for a Subscriber's Spouse enrolled as a Dependent shall terminate on the first day of the month following the month in which a final judgment or decree of dissolution of marriage is entered. A Dependent child's membership in this Dental Plan shall continue notwithstanding dissolution of Subscriber's

marriage for as long as Dependent child remains eligible and Dental Plan Premiums are received by PD. Notwithstanding the foregoing, Dependents may be eligible to elect continuation of benefits and/or conversion rights pursuant to Section 11 of this Agreement.

c. Death of Subscriber, (Dependent Eligibility). In the event the Subscriber dies, then coverage for individuals enrolled as Dependents shall terminate on the first day of the month following the month in which the Subscriber died. Notwithstanding the foregoing, Dependents may be eligible to elect continuation of benefits and/or conversion rights pursuant to Section 11 of this Agreement.

10.01.05 Member Fraud or Deception. A Member's membership in this Dental Plan shall immediately terminate if such Member knowingly provides PD with fraudulent information upon which PD relies, which materially affects Member's eligibility for enrollment or benefits under this Dental Plan. In such instance, PD shall send a written notice of termination to Member.

10.01.06 Member Permits Misuse of Identification Card. A Member's membership in this Dental Plan shall immediately terminate if such Member permits the use of his or her PD Identification Card by any other person. In such instance, PD shall mail a written notice of termination to the Member.

10.01.07 Disenrollment for Cause. A member may be disenrolled for cause if the Member's behavior is disruptive, threatening, unruly, abusive, or uncooperative to the extent that his or her continuing membership in the Dental Plan seriously impairs PD's ability to furnish or arrange services to the Member or other Members. In addition, a member may be disenrolled for continued refusal of recommended dental treatment as described in section 4.07 of this Agreement. A disenrollment for cause shall be effective on the first day of the calendar month following the month in which notice of disenrollment is given to the Member. If the basis for the Member's behavior is the relationship with the provider, the Member will be given the opportunity to switch to another provider before disenrollment.

10.01.08 Voluntary Disenrollment by Member. A Member may voluntarily disenroll by submitting a written request for disenrollment to the Group in a manner to be determined by the Group. If the request complies with Group requirements, the Group shall forward all such requests to PD for processing. The Group shall be responsible for payment of the Member's Dental Plan Premium for the month in which the Member disenrolls.

10.01.09 Failure to Cooperate with PD's Third Party Lien and Coordination of Benefits Rights. PD may terminate a Member if the Member fails to reasonably cooperate with PD in the enforcement of PD's lien rights as required by Sections 12 and 13 or in PD's efforts to coordinate benefits with other plans as required by

Section 13. Termination shall be effective the last day of the month in which Member receives notice of termination.

10.02 Written Notice of Termination. When a written notice of termination is sent to the Member pursuant to Paragraph 9 or 10 of this Agreement, it shall be dated and state:

a. The cause of termination with specific reference to the Paragraph of this Agreement giving rise to the right of termination;
b. That the cause for termination was not the Member's health status or *requirements for health care services;*
c. The effective date of termination;
d. That notwithstanding the Member Grievance procedure set forth at Paragraph 7.01 of this Agreement, if Member believes that his or her Dental Plan membership has been terminated because of his or her health status or requirements for health care services, Member may request a review before the Commissioner of Managed Health Care for the State of California.

10.03 Nonliability After Termination. Except as provided in Paragraph 11.02 of this Agreement, upon termination of this Agreement for any reason, PD shall have no further liability to provide benefits to any Member, including, without limitation, those Members hospitalized or undergoing treatment for an ongoing condition. Member's rights to receive benefits hereunder shall cease upon the effective date of termination.

11. CONTINUATION OF BENEFITS AND CONVERSION

11.01 Continuation of Benefits Under COBRA. Continuation coverage under this Dental Plan shall be available to Members through Group under the Consolidated Omnibus Reconciliation Act of 1985 (PL 99-272) ("COBRA") as amended by the 1986 Tax Reform Act (PL 99-514) and the 1986 Omnibus Reconciliation Act (PL 99-509). The continuation coverage under this Section 11.01 shall be equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan.

11.01.01 Notice Regarding Continuation Coverage. Group shall provide written notice to each Member enrolled through Group of the continuation coverage available to Members under COBRA and the amendments thereto.

11.01.02 Premium for Continuation of Benefits. The Dental Plan premium for Continuation Members shall be equal to the Dental Plan premium for similarly situated regular Group Members plus any surcharge or administrative fee that can be charged to the Members as allowed by law. Group shall be solely responsible for collecting Dental Plan premiums from Continuation Members and shall transmit such premiums to PD along with the group Dental Plan premiums otherwise due under this Agreement. Group shall maintain accurate records regarding Continuation Member dental premium payments, qualifying events,

terminating events and other information necessary to administer this continuation benefit.

11.02 Extended Cobra Coverage Under California State Law. Continuation coverage following COBRA coverage may be available to Subscriber and the Subscriber's Spouse (including Subscriber's Former Spouse where applicable) if the Subscriber or Spouse is older than 60, under 65, and if the Subscriber worked for the Group for at least five years prior to the date of termination of Subscriber's employment. Such continuation coverage following COBRA coverage will be provided in accordance with Section 1373.621 of the California Health & Safety Code. The Dental Plan Premium for the Subscriber or Subscriber's Spouse eligible for continuation coverage under this Paragraph 11.02 shall be equal to 213% of the Dental Plan Premium for similarly situated regular Group Members. Group is required to notify any eligible COBRA Participant of his or her eligibility for continuation coverage under this Paragraph 11.02 in writing at least 30 days prior to the date that COBRA coverage is scheduled to end.

THE FOLLOWING PROVISION APPLIES ONLY TO INDIVIDUALS ENROLLED AS A PARTICIPANT IN A GROUP OF 2-19 MEMBERS

11.03 Cal-COBRA Continuation Coverage. As a result of the California Continuation Benefits Replacement Act (Cal-COBRA), effective January 1, 1998, if enrolled in a PacifiCare small group benefit plan, the subscriber, or subscriber's covered dependents may be entitled to continue their small group health care coverage with PacifiCare despite the occurrence of certain "Qualifying Events" that would otherwise have resulted in a loss of coverage. Under Cal-COBRA, the subscriber and covered dependents will generally receive the same benefits they had previously received under their employer's group benefit plan, unless the employer changes dental plans or PacifiCare Dental changes the benefits all members receive under the employer's group benefit plan. Cal-COBRA continuation coverage will be provided under the same terms and conditions that apply to similarly situated individuals under the group benefit plan.

11.03.01 Eligibility of Cal-COBRA. In order to be eligible for Cal-COBRA continuation coverage, you must work for a small employer that: (a) employed 2-19 eligible employees on at least 50% of its working days during the preceding calendar year, or if the employer was not in business during any part of the previous calendar year, employed 2-19 eligible employees on at least 50% of its working days during the preceding calendar quarter, and (b) is not subject to the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). **The employer must determine whether or not the subscriber is entitled to continuation coverage under federal COBRA.** If so, the subscriber may be able to continue his/her small employer group dental care coverage at a lower cost to than under Cal-COBRA.

If the employer meets the above conditions, the subscriber and covered dependents may qualify for Cal-Cobra continuation coverage if they lose coverage as a result of one of the following "Qualifying Events":

a. Termination of employment or reduction in work hors for reasons other than gross misconduct.
b. Subscriber's death.
c. The subscriber's spouse ceases to be eligible due to divorce or legal separation.
d. The loss of dependent status by a dependent enrolled in the group benefit plan.
e. With respect to a covered dependent only, the Subscriber's entitlement to Medicare.

11.03.02 Notification of Qualifying Events. It is the responsibility of the subscriber to notify PacifiCare Dental of the occurrence of any of the above Qualifying Events within 60 days, except that the employer must notify PacifiCare Dental within 30 days of the occurrence of a termination of employment or reduction in work hours which would result in loss of coverage under the group benefit plan. **Failure to notify PacifiCare Dental of the occurrence of a Qualifying Event within 60 days will disqualify the Subscriber from receiving continuation coverage.** The Subscriber should contact either PacifiCare Dental or his/her employer for a copy of the Qualifying Event Notification Form which should be used to notify PacifiCare of the occurrence of a Qualifying Event. All notifications of Qualifying Events must be submitted to PacifiCare Dental in writing at the following address: PacifiCare Dental, Membership Accounting, 2099 S. State College Blvd., Ste. 500, Anaheim, California 92806.

11.03.03 Cal-COBRA Enrollment and Premium Information. Within 14 days of receiving a Qualifying Event Notification Form, PacifiCare Dental will sent the subscriber enrollment and premium information, including a Cal-Cobra Election From. In order to enroll in Cal-COBRA, PacifiCare Dental must receive the completed Cal-COBRA Election Form and Cal-COBRA premium payment within the specified time periods, The Cal-COBRA Election Form must be delivered to PacifiCare Dental by first-class mail (or other reliable means of delivery within 60 days of the occurrence of the last of the following: (a) the date coverage under the group benefit plan terminated or will terminate by reason of a Qualifying Event; or (b) the date the Subscriber/Covered Dependents were sent Cal-COBRA enrollment and premium information.

The first Cal-COBRA premium payment must be received by PacifiCare Dental within 45 days of the date PacifiCare Dental receives the Cal-COBRA Election Form. **Failure to submit the correct premium amount within the 45-day period will disqualify the Subscriber/Covered Dependents from receiving Cal-COBRA continuation of coverage.** This premium payment must be an amount sufficient to pay all premiums due from the first month after the Qualifying Event through the current month. Thereafter, Cal-COBRA premiums are due on the first day of the coverage month (i.e., January 1st for January

coverage). The Cal-COBRA premium will generally be 110% of the premium charged to the employer for similarly situated active employees. Please note there will not be any enrollment in Cal-COBRA until PacifiCare Dental received both the Cal-COBRA Election From and the first Cal-COBRA premium payment.

11.03.04 Termination of Cal-COBRA Continuation Coverage. Generally, Cal-COBRA continuation coverage will last 18 months if the Subscriber/Covered Dependent became eligible for Cal-COBRA coverage as a result of a termination of employment or reduction in hours, and 36 months if the Subscriber/Covered Dependent became eligible for Cal-COBRA coverage for any other reason. Your Cal-COBRA continuation coverage may terminate early if you move out of PacifiCare Dental's service area, fail to pay the required premium within 15 days of the due date, or commit fraud or deception the use of plan services. If the employer group benefit plan with PacifiCare Dental is terminated prior to the date that the Cal-COBRA continuation coverage would otherwise expire, coverage with PacifiCare Dental will expire and the Subscriber/Covered Dependent will be given an opportunity to continue coverage under a subsequent group benefit plan purchased by your employer, if any. Should your employer purchase a subsequent group benefit plan, the successor plan will send out premium information, enrollment forms and other instruction necessary to continue coverage under the subsequent group benefit plan. Because this information will be sent to the Subscriber/Covered Dependent's last known address, it is important to keep PacifiCare Dental informed of any address changes. The successor plan will only be obligated to provide continuation coverage for the balance of the Cal-COBRA continuation coverage period. **Please note that Cal-COBRA continuation coverage will terminate if the Subscriber/Covered Dependent fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the subsequent group benefit plan within 30 days of receiving notice of the termination of the PacifiCare Dental group benefit plan.**

11.04 Individual Conversion Contract. Upon termination of a Subscriber's coverage under this Dental Plan, including termination because a Member is no longer eligible for benefits under COBRA, Subscriber may apply for and receive PD individual conversion. Coverage on behalf of the Subscriber and his or her Dependents shall be subject to the terms, conditions and limitations of this Section 11.03 and subsections hereto. The terms and conditions of Individual Conversion Coverage are set forth in the PD Individual Conversion Subscriber Agreement, copies of which are available from PD upon request. The Individual Conversion Subscriber Agreement shall cover the Subscriber and all Dependents who were covered under this Dental Plan on the date of their termination under this Dental Plan.

11.04.01 Dependent Conversion Rights. A Dependent spouse who loses eligibility as the result of the death of a Subscriber or divorce from a Subscriber may apply for and receive conversion coverage on behalf of the dependent spouse and his or her dependent children who also lose their eligibility. A dependent

child may apply for and receive conversion coverage individually only if the dependent child loses eligibility and the event leading to the dependent child's loss of eligibility does not affect the eligibility of the Subscriber through whom the dependent child obtains eligibility or the dependent spouse of such Subscriber. A Dependent's conversion rights are subject to the terms, conditions and limitations of this Section 11.03 and subsections hereto.

11.04.02 Limitations on Conversion Rights. Conversion to individual coverage shall not be allowed if:

a) Coverage under the Dental Plan terminated due to Member's failure to make timely payment of a required payment under the Dental Plan;
b) The Dental Plan terminated or Group terminated participation under the Dental Plan;
c) Member's coverage is terminated pursuant Section 10 of this Agreement;
d) The Member did not have continuous coverage under the Group's PD Plan for the three (3) months immediately preceding the termination of coverage.

11.04.03 Notice of Individual Conversion Rights. Within fifteen (15) days after a Member's termination, the Group shall notify the Subscriber on behalf of the Subscriber and his or her dependents or, if no Subscriber is available, any terminated Dependent, of the availability, terms and conditions of the PD conversion coverage.

11.04.04 Application Deadline. To exercise the conversion privilege set forth in this Section 11.04, the terminated Subscriber or Dependent, as applicable, must submit a written application and the applicable Dental Plan premium no later than thirty-one (31) days after the date the Subscriber's or Dependent's coverage terminated under this Dental Plan. The individual conversion shall become effective immediately following the termination of coverage under this Dental Plan.

12. THIRD PARTY LIABILITY

12.01 Third Party Liability. To the extent permitted under applicable federal and state law and as provided for in this Agreement, in the case of injuries caused by any act or omission of a third party, and any complications incident thereto, the benefits of this Agreement shall be furnished by PacifiCare to Member. Member agrees, however, to reimburse PacifiCare, or its nominee, for the cost of all such services and benefits provided, to the extent allowed under state and federal law, immediately upon obtaining a monetary recovery, whether due to judgment, arbitration award, or settlement agreement on account of such injury. PacifiCare or its nominee shall have a lien on any such monetary recovery by Member, and Member shall hold any sum due to PacifiCare or its nominee pursuant to this Section 12.01 in trust. The amount of PacifiCare's or its

nominee's lien shall be determined in accordance with California Civil Code Section 3040, or any other applicable law in effect at the time the lien arises.

Member agrees that PacifiCare's rights to reimbursement under this Section 12.01 are the first priority claim against any third party. This means that PacifiCare shall be reimbursed from any recovery before payment of any other existing claims, including any claim by the Member for general damages. To the extent permitted by state and/or federal law, and as set forth in this Section 12.01, PacifiCare may collect from the proceeds of any settlement or judgment recovered by Member or his or her legal representative regardless of whether the Member has been fully compensated.

Member agrees to cooperate in protecting the interests of PacifiCare under this provision. Member must execute and deliver to PacifiCare or its nominee any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the right of PacifiCare, or its nominee, including, but not limited to, the granting of a lien right in any claim or action made or filed on behalf of Member and the signing of documents evidencing same. Member's failure to cooperate with PacifiCare in a reasonable manner as provided in this Section 12.01 may result in such Member's termination from this Health Plan.

Member shall not settle any claim, or release any person from liability, without the written consent of PacifiCare, wherein such release or settlement will extinguish or act as a bar to PacifiCare's rights of reimbursement.

In the event PacifiCare employs an attorney for the purpose of enforcing any part of this section against a Member based on Member's failure to cooperate with PacifiCare, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees.

13. NONDUPLICATION OF BENEFITS/COORDINATION OF BENEFITS

13.01 Workers' Compensation. PD shall not furnish benefits under this Agreement to any Member which duplicate the benefits to which such a Member is entitled under any applicable Workers' Compensation law. The Member is responsible for taking whatever action is necessary to obtain payment under Workers' Compensation laws where payment under that system can be reasonably expected. Failure to take proper and timely action under such circumstances will preclude PD's responsibility for furnishing such benefits on behalf of such a Member to the extent that payment of such benefits could have been reasonably expected under Workers' Compensation laws had such action been taken. If a Member receives a settlement of Workers' Compensation benefits which includes any compensation for future dental costs, the Member will be liable to pay for or reimburse PD for any Covered Services relating to the injury or illness.

In the event of a dispute, arising between the Member and their Workers' Compensation coverage, as to the Member's ability to collect under Workers' Compensation laws, PD will provide the benefits described in this Agreement until resolution of the dispute.

In the event PD for any reason provides benefits which duplicate the benefits to which a Member is entitled under Workers' Compensation law, the Member agrees to reimburse PD, or its nominee, for the cost of all such services and benefits provided by PD, at Prevailing Rates, immediately upon obtaining a monetary recovery, whether due to settlement or judgment. The Member shall hold any sum collected as the result of a Worker's Compensation action in trust for PD. Such a sum shall not exceed the lesser of the amount of the recovery obtained by the Member or the reasonable value of all services and benefits furnished to the Member or on the Member's behalf by PD on account of each incident.

The Member may receive a Workers' Compensation settlement that includes future treatment. The Member may then be liable for cost of treatment for Workers' Compensation injury after the settlement.

The Member agrees to cooperate in protecting the interests of PD under this provision. The Member must execute and deliver to PD, or its nominee, any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of PD, or its nominee, including, but not limited to, the granting of a lien right in any claim or action made or filed on behalf of Member and signing any documents evidencing such lien. A Member's failure to cooperate with PD in a reasonable manner as provided in this Section may result in such Member's termination from this Dental Plan.

13.02 Automobile, Accident or Liability Coverage. PD, or its nominee, shall not furnish benefits under this Agreement which duplicate the benefits to which a Member is entitled under any other automobile, accident or liability coverage. Member is responsible for taking whatever action is necessary to obtain the benefits of such coverage when it is available and shall notify PD of such coverage when available. If payment or services are provided by PD and/or its nominee in duplication of the benefits available to the Member under other automobile, accident or liability coverage, PD and/or its nominee may seek reimbursement to the extent of the reasonable value of the benefits provided by PD from the insurance carrier, Provider, and/or Member, to the extent permitted under state and/or federal law

Should the cost of Dental Services exceed the coverage of any applicable other coverage pursuant to this Paragraph 13.02, PD benefits shall be provided over and above such coverage.

Member's failure to cooperate with PD in a reasonable manner in PD's efforts to secure payment from another carrier may result in such Member's termination from this Dental Plan.

13.03 Coordination of Benefits. All of the benefits provided under this Dental Plan are subject to this provision. These coordination of benefit rules shall be applied in accordance with the coordination of benefits regulations, and interpretive instructions,

promulgated by the California Department of Managed Health Care, as amended from time to time, which are incorporated into this Agreement.

13.03.01 Plan Defined. "Plan" as used in this Paragraph 13.03 means any of the following which provides for benefits or services for, or by reason of, dental care or treatment:

a) Group, blanket or franchise insurance coverage;
b) Service plan contracts, group practice, individual practice and other prepayment coverage;
c) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
d) Any coverage under governmental programs, and any coverage required or provided by any statute, except entitlements to dental benefits or benefits under the California Crippled Services Program or any other coverage provided for or regulated by law when, by law, its benefits are excess to any private insurance or any other non-governmental program.

Each contract or other arrangement for coverage described above is a separate Plan. If an arrangement has two parts and the coordination of benefits provisions apply only to one of the two, each of the parts is a separate Plan.

13.03.02 Effect on Benefits.

a. This provision shall apply in determining the benefits as to a Member for any Claim Determination Period if the Allowable Expenses incurred as to such Member during such period would be less than the sum of:
    i. the value of the benefits that would be provided by this Plan in the absence of this provision, plus
    ii. the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision.
b. As to any Claim Determination Period to which this provision is applicable, the benefits that would be provided under this Plan in the absence of this provision for the Allowable Expenses incurred as to the Member during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in part (c) to this Paragraph 13.04.02, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had the claim been made therefor.
c. If:

i. another plan which is involved in this Paragraph 13.03.02(b) and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
ii. the rules set forth in Paragraph 13.03.03 would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

13.03.03 Order of Benefit Determination Rules. For the purposes of Paragraph 13.03.02, the rules establishing the order of determination are:

a. The benefits of a Plan which covers the Member on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such Member as a dependent.
b. Except as stated in Paragraph 13.03.03(c) below, the benefits of the Plan of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan of the parent whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of the Paragraph regarding dependents, which results either in each Plan determining its benefits after the other, the provisions of this Paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this Paragraph shall determine the order of the benefits.
c. In the case of a Member for whom a claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.
d. In the case of a Member for whom a claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.
e. In the case of a Member for whom a claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules (c) and (d), the benefits of a Plan which

covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

f. When rules (a) through (e) do not establish an order of benefit determination, the benefits of a Plan which has covered the Member for the longer period of time shall be determined before the benefits of a Plan which has covered such Member the shorter period of time, provided that:
    i. the benefits of a Plan covering the person on whose expense claim is based as a laid-off or retired employee, or dependent of such person shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and
    ii. if either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then rule (f)(i) shall not apply.

g. When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

13.03.04 Right to Receive and Release Necessary Information. For the purpose of determining the applicability of and implementing of the terms of this provision of this Dental Plan or any provision of similar purpose of any other Plan, this Dental Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision. A Member's failure to cooperate with PD in a reasonable manner in its efforts to secure payment from another carrier may result in such Member's termination from this Dental Plan.

13.03.05 Allowable Expense. "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of such services rendered shall be deemed to be both an Allowable Expense and a benefit paid.

13.03.06 Claim Determination Period. "Claim Determination Period" means a calendar year.

13.03.07 Facility of Payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any

other Plans this Dental Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Dental Plan and, to the extent of such payments, this Dental Plan shall be fully discharged from liability under this Dental Plan.

13.03.08 Right of Recovery. Whenever payments have been made by this Dental Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Plan shall determine: any persons to or for or with respect to whom such payments were made, any insurers, service plan or any other organizations.

14. MISCELLANEOUS PROVISIONS

14.01 Governing Law. This Agreement is subject to the laws of the State of California and the United States of America, including: the California Health and Safety Code and the regulations promulgated thereunder by the Department of Managed Health Care of the State of California; the Health Maintenance Organization Act of 1973 and regulations promulgated thereunder by the Department of Health and Human Services of the United States, and the Employee Retirement Income Security Act of 1974, as amended. Any provisions required to be in this contract by any of the above acts and regulations shall bind PD and its Members, whether or not expressly provided in this Agreement.

14.02 Use of Name in Promotional/Marketing Materials. PD reserves the right to control all use of its name, symbols, trademarks or service marks currently existing or later established. However, either party may use the other party's name, symbols, trademarks or service marks with the prior written or verbal approval of the other party in advertising or other promotional materials relating to this agreement.

14.03 Assignment. This agreement and the rights, interests, and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by either party and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the approval of the other party. Notwithstanding the above, if PD assigns, sells, or otherwise transfers substantially all of its assets and business to another corporation, firm, or person, with or without recourse, this Agreement will continue in full force and effect as if such corporation, firm, or person were a party to this Agreement provided such corporation, firm, or person continues to provide prepaid health services.

14.04 Validity. The unenforceability or invalidity of any paragraph of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

14.05 Confidentiality. PD agrees to maintain and preserve the confidentiality of any and all dental records of its Members. However, a Member authorizes the release of information and access to any and all of Member's dental records for purposes of Utilization Review, Quality Assurance, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this Agreement to PD, its agents and employees, Member's Participating Dental Group/IPA/Dentist, and appropriate governmental agencies. PD shall not release any information to the Group which would directly or indirectly indicate to the Group that a Member is receiving or has received Covered Services, unless authorized to do so by the Member.

14.06 Amendments. This Agreement may be modified by PD as set forth in paragraph 3.07, or it may be amended upon the mutual written consent of the parties.

14.07 Group Use of Administrative Manual. The Group agrees to use the Administrative Manual provided by PD and agrees to conform to policies and procedures in the Administrative Manual. PD agrees to provide thirty (30) days notice to the Group of any changes in the Administrative Manual. In the event of conflict between this Agreement and the Administrative Manual, the term of this Agreement shall prevail.

14.08 Attachments. The Dental Group Member Agreement Cover Sheet and appropriate Attachments attached hereto are incorporated by reference and made an integral part of this Agreement.

14.09 Use of Gender. The use of masculine gender in this Agreement includes the feminine gender and the singular includes the plural.

14.10 Waiver of Default. The waiver by PD of any one or more defaults by a Group or Member shall not be construed as a waiver of any other or future defaults, under the same or different terms, conditions or covenants contained in this Agreement.

14.11 Notices. Any notice required to be given under this Agreement shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other addresses as the parties may hereafter designate:

If to PD: PacifiCare Dental
3110 Lake Center Dr
Santa Ana, California 92704-6921

If to a Group or Member, at the Group's or Member's last address known to PD.

14.12 Acceptance of Agreement. The Group may accept this Agreement either by execution of the Agreement or by making payment to PD of Dental Plan Premiums as specified herein. Such acceptance shall render all terms and provisions of this Agreement binding on PD, the Group and Members.

14.13 Entire Agreement. This Agreement contains the entire understanding of the Group and PD with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, or communications, whether written or oral, between the Group and PD with respect to the subject matter of this Agreement.

14.14 Benefit Changes. During the period of this contract, PD may not decrease or increase the Benefits stated in this contract in any manner except after a period of thirty (30) days from either the date of mailing or actual hand delivery to Group of written notice of such proposed change.

14.15 Discrimination Prohibited. PD shall not refuse to enter any contract or shall not cancel or decline to renew or reinstate any contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, handicap, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from any such contract as a member or otherwise.

The terms of any contract shall not be modified and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reduction, copayments, co-insurance, deductibles, reservations, or premium, price or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from any such contract as a member or otherwise; except that premium, price or charge differentials because of the sex or age of any such individual and based on objective, valid and up-to-date statistical and actuarial data are not prohibited.

14.16 Second Dental Opinions A Member, or his or her treating participating health professional, may submit a request for a second dental opinion to PD. Second dental opinions will be provided when requested.

The request for a second dental opinion will be processed in a timely fashion appropriate for the nature of the Member's condition. When the Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, a request for a second opinion shall be processed in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after PacifiCare's receipt of the request, whenever possible. When the Member's condition does not create an imminent and serious threat to his or her health, a request for a second opinion shall be processed in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days after receipt of the request by PacifiCare. Second dental opinions will be rendered by an appropriately qualified health care professional. An appropriately qualified health care professional is a primary care dentist specialist, or other licensed health care provider who is acting within his or her scope of practice and

who possesses the clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second dental opinion.

If the Member is requesting a second dental opinion about care received from his or her Assigned Dental Office, the second dental opinion will be provided by an appropriately qualified health care professional within the PD participating provider network, whenever possible. If the Member is requesting a second dental opinion about care received from a specialist, the second dental opinion will be provided by a specialist within the PD participating provider network of the same or equivalent specialty, whenever possible.

A second dental opinion is an examination by an appropriately qualified health professional documented by a consultation report. The consultation report will be made available to the Member and PD and may include any recommended procedures or tests that the second opinion dental professional believes are appropriate. If the Provider giving the second dental opinion recommends a particular treatment, diagnostic test or service covered by PD, the treatment, diagnostic test or service will be provided or arranged by the Member's Assigned Dental Office or by an appropriately qualified health care professional within the PD participating provider network. However, the fact that an appropriately qualified health care professional, furnishing a second dental opinion, recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is a Covered Service under the Member's PacifiCare Dental Plan. All care is subject to the limitations and exclusions of the Plan. The Member shall be responsible for paying any dental Copayments, as set forth in the Member's PacifiCare Dental Plan, to the PacifiCare participating provider who renders the second dental opinion to the Member.

To obtain a copy of the Second Medical Opinion Timeline, Members may call or write PacifiCare Member Service at:

PacifiCare Dental
P.O. Box 25187
Santa Ana, CA 92704

1-800-228-3384

15. EXECUTION

15.01 Execution of Agreement. The Group and PD accept the terms, conditions and provisions of this Agreement and upon execution of this agreement, the Member accepts the terms, conditions and provision of this Agreement upon completion and execution of the Enrollment Form.

15.02 Arbitration. PD USES BINDING ARBITRATION TO RESOLVE ANY AND ALL DISPUTES BETWEEN PD AND THE GROUP OR MEMBER, INCLUDING, BUT NOT LIMITED TO, ALLEGATIONS AGAINST PD OF

MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY DENTAL SERVICES RENDERED UNDER THE PACIFICARE DENTAL PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED) AND OTHER DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PACIFICARE DENTAL PLAN. PD, THE GROUP AND MEMBER EACH UNDERSTAND AND EXPRESSLY AGREE THAT BY ENTERING INTO THE PACIFICARE DENTAL SERVICES GROUP SUBSCRIBER AGREEMENT OR ENROLLING IN THE PACIFICARE DENTAL PLAN AND AGREEING TO BE BOUND BY THE PACIFICARE SUBSCRIBER AGREEMENT, PACIFICARE, THE GROUP AND MEMBER ARE EACH VOLUNTARILY GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ALL SUCH DISPUTES DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. THE GROUP AND MEMBER FURTHER UNDERSTAND THAT ANY DISPUTES BETWEEN THE GROUP AND MEMBER AND A PD CONTRACTING PROVIDER, INCLUDING, BUT NOT LIMITED TO, CLAIMS AGAINST A PD CONTRACTING PROVIDER FOR MEDICAL MALPRACTICE, ARE NOT GOVERNED BY THE PACIFICARE SUBSCRIBER AGREEMENT. HOWEVER, PD, THE GROUP AND MEMBER EACH EXPRESSLY AGREE THAT THE EXISTENCE OF ANY DISPUTES BETWEEN THE GROUP OR MEMBER AND A PD CONTRACTING PROVIDER, INCLUDING, BUT NOT LIMITED TO, CLAIMS BY A GROUP OR MEMBER AGAINST A PD CONTRACTING PROVIDER FOR MEDICAL MALPRACTICE, SHALL IN NO WAY AFFECT THE OBLIGATION TO SUBMIT TO BINDING ARBITRATION ALL DISPUTES BETWEEN GROUP OR MEMBER AND PD.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in Santa Ana, California, on [June 30, 2005].

PACIFICARE DENTAL

BY _____

John W. Whalley
Vice President, Mid-Market Sales and Service

PACIFICARE DENTALAND VISION ADMINISTRATORS

BY _____

Kelly McCrann
President

APPROVED AS TO FORM
12/30, 2005
ROBERT E SHANNON, City Attorney
BY _____
SENIOR DEPUTY CITY ATTORNEY

CITY OF LONG BEACH

BY _____

Name: Gerald R. Miller

Title: City Manager

State of California
City of Long Beach

On June 30], 2005 before me, [Patricia Sanders], personally appeared John W. Whalley, Vice President, Mid-Market Sales and Service and Kelly McCrann, Presiden..

[✓] proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) ~~is~~/are subscribed to the within instrument and acknowledge to me that ~~he/she~~/they executed the same in ~~his/her~~ their authorized capacity(ies), and that by ~~his/her~~/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____
Patricia Sanders, Notary Public

PATRICIA SANDERS
Comm. # 1353491
NOTARY PUBLIC - CALIFORNIA
Los Angeles County
My Comm. Expires April 25, 2006

EXHIBIT A

Signature Value 120 Dental Plan
DESCRIPTION OF BENEFITS AND CO-PAYMENTS

The Company agrees to provide benefits to Members of the Organization as set forth in the Benefit Schedule enclosed with this agreement. This schedule establishes the dental care services which are available without charge (designated as "no Charge" in the schedule), and those services for which members are obligated to pay the Professional Provider who is permitted to charge for specific dental care services as set forth under the heading "Co-payment Required" and is payable at the time services are rendered.

EXHIBIT B

LIMITATION OF BENEFITS

1. WORKERS' COMPENSATION - Should any benefit or service be rendered as a result of a Workers' Compensation Injury Claim, the Member shall assign his/her right to reimbursement from other sources to PD or the Participating Provider who rendered the services. Any reimbursement in excess of the reasonable value of the services performed, subject to Section 3 of the Group Subscriber Agreement, shall be refunded by PD or the Participating Provider who rendered the services.

2. PROPHYLAXIS - Routine cleaning of teeth, including polishing and required supragingival (above the gum) and coronal scaling, is an allowable preventive benefit semi-annually, or annually, depending on the Member's Schedule of Principal Benefits and Coverage.

3. FULL MOUTH RADIOGRAPHS (X-rays) are limited to once in a two-year period. Bite wing x-rays are limited to no more than one series of four in any six month period.

4. FLUORIDE TREATMENTS are limited to only once per calendar year.

5. PERIODONTAL CURETTAGE AND ROOT PLANING - Both procedures are allowable only when the need can be demonstrated radiographically and/or by pocket charting. There is a maximum of four quadrants per calendar year.

6. PERIODONTAL MAINTENANCE PROCEDURES (ADA procedure #4910) – is a benefit following active therapy once every six months at the Specialist's office when referred by the general dentist, or at the General Practice Office.

7. PROSTHETICS

   A. <u>REMOVABLE PROSTHETICS</u>

      1) Temporary or Transitional Dentures
      Temporary or transitional full dentures are not a covered benefit. However, with some benefit packages, an exception is made for an anterior stayplate when this interim appliance either:
      a) Replaces natural, permanent, anterior teeth, during the healing period immediately after extraction or traumatic tooth loss; or
      b) Replaces extracted or lost natural, permanent, anterior teeth for Members under 16 years of age.

      2) Partial and Full Dentures
      a) When permanent teeth are missing, a fixed bridge and/or a tooth supported partial denture is covered. Coverage is dependent upon:

i. The exclusions and limitations of the Plan, herein disclosed; and

ii. The specific treatment recommendations of your assigned dentist in concert with the patient subject to clinical appropriateness to best meet the patient's needs and restore function.

b.) Laboratory upgrades include, but are not limited to:

i Precious metal for removable appliance framework or a metal base for a full denture

ii "Personalization" and characterization

iii Special denture teeth

3) Specialized Services and Laboratory Upgrades for Dentures
Charges for specialized techniques involving precision attachments or stress breakers are not covered benefits. Denture "personalization", characterization, or special teeth are laboratory upgrades, which are limited to the amount actually charged by the dental laboratory for the upgrade.

4) Denture Repairs and Relines

a) For existing full or partial dentures, the addition of new denture teeth is covered if a natural tooth or a denture tooth is lost. Replacement of an existing full or partial denture is covered only if the existing denture has been determined unserviceable and can not be made serviceable, by the assigned primary care dentist.

b) If an existing permanent denture needs to be repaired and/or relined to be made serviceable, then repairs and/or relines are also a benefit. The addition of denture teeth, repairs and relines of secondary ("back-up", "spare" or "temporary") dentures are not covered benefits.

c) Denture adjustments - Adjustments for new dentures are included in the copayment for the denture for six months following delivery. For existing dentures, or new dentures after the initial six months, the Member is responsible for the listed copayment for a denture adjustment. Adjustments of secondary ("back-up" or "spare") dentures are not a covered benefit.

B. FIXED PROSTHETICS:

A fixed bridge is a benefit to replace missing natural teeth, unless:

1) The clinical condition of the teeth that would support the bridge is unfavorable.
2) There are inadequate teeth available to support the bridge.

3) The same dental arch has a serviceable existing partial denture to which additional denture teeth may be added to replace the missing natural teeth.
4) A Member under 16 years of age loses a permanent tooth; in which case an interim anterior stayplate would be the covered benefit to replace the missing tooth.
5) The new bridge would replace an existing bridge that is still serviceable.
6) The bridge would be supported in whole or in part by dental implants, or acid-etched resin bridge retainers (a "Maryland" bridge).
7) A bridge would be used only to realign malaligned teeth.
8) It is a long spanning bridge (anything beyond four (4) abutments and/or pontics).

C. SINGLE CROWNS, INLAYS AND ONLAYS

Single crowns, inlays and onlays will be covered when there is not enough retentive quality left in a tooth to hold a filling; or if the tooth requires cuspal protection to avoid an unacceptable risk of tooth fracture. The use of precious or semi-precious metals in crowns is considered a laboratory upgrade, which the primary care dentist may offer the Member for a fee not to exceed the amount charged the dentist by the dental laboratory for the use of these upgraded metal alloys. The primary care dentist may not, however, charge any additional laboratory fee in excess of the listed copayment if a base metal alloy is used in a crown.

1) Replacement of an inlay, onlay or crown is a covered benefit as long as the existing restoration is unserviceable, and can not be made serviceable, as determined by the assigned primary care dentist.
2) For crowns and fixed bridges, the maximum benefit within a twelve month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than seven crowns and/or pontics are done for a patient within a twelve month period, the dentist's fee for any additional crowns within that period would not be limited to the listed copayment, but instead can reflect the dentist's UCR.

8. OCCLUSAL EQUILIBRATION - The correction of occlusion on natural teeth or existing restorations is not a covered benefit. Adjustment of the bite on a new restoration, crown, bridge, and denture will be provided at no additional charge, if performed by the dentist who provided the service.

9. DOWEL POSTS AND PINS - Dowel posts are a benefit for teeth that have had root canal therapy and lack sufficient structure to otherwise support and retain a crown. Pins

are a separate covered benefit if deemed by the dentist necessary to provide adequate retention of a restoration

10. SPECIALTY REFERRAL - The liability of PD is per calendar year, per family above the Member's copayment for such specialty treatment. Any fees in excess of the copayment and PD's liability are the responsibility of the Member.

    The BENEFIT of dental treatment by a specialist is limited to:

    - Covered dental services performed by an Oral Surgeon, Endodontist, Periodontist and Pedodontist, which are beyond the scope of practice of a general dentist; and services by an Orthodontist, if the Member's benefit package specifically includes PVD's orthodontic benefit.
    - Pedodontic referrals apply to all children through age 18 as necessary.

11. RESTORATIONS AND DENTAL PROSTHETICS - Restorations and/or fixed or removable prosthetics needed solely to increase vertical dimension or restore the occlusal plane are not covered benefits. Restore the Occlusal plane means oral rehabilitation using crown(s), bridge(s), filling(s), and/or denture(s) to establish an altered bite or relationship between the jaws.

12. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

EXHIBIT B-1

GOVERNING ADMINISTRATIVE POLICIES

Set forth below are the administrative policies which are applicable to this Plan.

1. NON-COVERED BENEFITS
Assigned primary care dentists and contracted dental specialists may offer Members dental services that are not included on the list of covered benefits, and for which there are not alternative listed covered services. In such cases, the dentist may offer the service for the office's UCR. For example, if a dentist offers, and the patient consents to cosmetic tooth bleaching, there is no alternative covered benefit and the dentist may charge UCR.

2. LABORATORY UPGRADES are:

   A. Dental Laboratory Upgrades to a Covered Procedure:
   Fees for upgrades such as precious or semi-precious metal alloys; upgraded denture teeth; permanent denture soft acrylic bases; and denture characterization or "personalization" will be limited to the additional laboratory fee charged the dentist by the dental laboratory for the upgrade. For example, the dentist offers, and the patient accepts, the alternative of a precious (gold) crown instead of a base metal crown. The dentist may charge no more than the listed copayment for the base metal crown, plus the actual fee charged by the dental laboratory for the use of the precious metal.

   B. Treatment plan decision making when two or more treatment alternatives are covered benefits:
   • When several covered services are treatment alternatives for <u>needed</u> care, all treatment alternatives are considered covered benefits. The determination of which covered service best meets the patient's needs is the decision or judgment of the treating dentist in concert with the patient. In this instance, either chosen service would be available to the patient at the listed copayment for the chosen covered services. The best example, but certainly not the only example, of this situation is the decision with regard to the replacement of bilateral missing teeth. In this scenario, either the removable partial denture or the fixed bridges would be considered covered services. The choice would be made by the dentist and patient considering professionally recognized standards of care, clinical condition of each restoration, technical difficulty of both restorative alternatives, and any other factors that may be present with regard to the patient's specific dental condition.

3. REMOVABLE DENTURES

   Please refer to Exhibit B, Section 7-A, Removable Prosthetics.

4. RESTORATIONS "FILLINGS" AND CROWNS

A. PD coverage provides for amalgam, composite, resin, and/or tooth-colored filling material restorations for treatment of decay or broken teeth. If a tooth can be restored with such materials, any cast restoration (crown, inlay or onlay) is considered Not Covered. If performed, the patient must pay the dentist's UCR fee.

B. Porcelain, porcelain-fused to metal (PFM), and cast metal crowns are not a benefit for children under 16 years of age. The benefit in such cases is a prefabricated stainless steel or resin crown. If a porcelain, PFM, or cast metal crown is performed, the parent or guardian must pay the dentist's UCR fee.

C. If an inlay, onlay, porcelain, PFM, or cast metal crown is serviceable, its replacement is not a covered benefit.

5. FIXED BRIDGES

A. PD will not allow for a new bridge and a new partial denture in the same arch. In such cases the covered benefit is for a partial denture that would replace all missing teeth in the arch or multiple bridges. See Section 2 B above.

B. Fixed bridges are not a benefit for patients under sixteen years of age. In such a case, the benefit is for a removable stayplate, or space maintainer. If the bridge is performed, patient or guardian must pay the Optional Treatment Fee (see Section XII 2 B).

C. If an existing bridge is serviceable, its replacement is not a covered benefit.

EXHIBIT C

EXCLUSION OF BENEFITS

The following procedures and services are excluded and not covered benefits:

1. Specialty referral benefits are not available unless otherwise indicated in the Schedule of Principal Benefits and Coverage in Exhibit A.

2. Services provided by a prosthodontist.

3. Cosmetic dental care.

4. The provision of dental services in hospitals, extended care facilities, or Members' homes.

5. Treatment of fractured bones and dislocated joints.

6. Lost or stolen dentures are not covered. Crowns, or bridgework lost due to negligence, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation, or poor margins (as previously determined in an examination by the assigned dentist or based upon a review of a pre-existing radiograph).

7. Lost, stolen or broken orthodontic appliances.

8. Services which are provided to the Member by a state government or agency thereof, or are provided without cost to the Member by a municipality, county or other subdivision.

9. Dental expense incurred in connection with any dental procedure started after termination of eligibility for benefits.

10. Work-in-progress: The completion of dental or orthodontia services started before the Member's effective date with PD, or started by a non-contracted dentist without the prior approval of PD. Note, this exclusion does not apply to a current Member who has a temporary placed, a tooth opened and medicated as a palliative service while out-of-area or when the assigned primary care dentist is unavailable to render palliative care.

11. The treatment of congenital and/or developmental malformations, which includes the treatment of congenitally missing and extra, supernumerary teeth and related pathology.

12. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms, and dysplasias.

13. Dental ridge augmentation, vestibuloplasties, and the excision of benign hyperplastic tissue.

14. Prescription drugs and over-the-counter medicines.

15. Any dental procedure unable to be performed in the dental office because of the patient's general health and physical limitations.

16. Oral surgery and procedures performed to facilitate or allow orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fiberotomy, gingivectomy, and surgery to uncover impacted teeth.

17. Services rendered by a dental office other than Member's assigned Participating Provider, unless previously authorized by PD in writing. An exception is made for emergency care, as defined herein.

18. Implants - The placement, maintenance, and removal of implants. Crowns and fixed prosthesis supported by implants are not covered benefits.

19. Restorations of natural teeth other than those needed for replacement of unserviceable existing restorations or to replace tooth structure lost due to fracture, endodontic access preparations, or dental caries. Such treatment includes, but is not limited to:
    - Replacing or stabilizing tooth structure loss by, abrasion or erosion
    - Periodontal splinting/grafting
    - The replacement of otherwise serviceable amalgam restorations, with new reiterations of a different material solely to eliminate the presence of amalgam

20. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion, alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofascial pain syndrome are not covered benefits. If performed the patient must pay UCR. These services include, but are not limited to:
    - Realignment of teeth
    - Gnathologic recording
    - Equilibration
    - Occlusal splints and night guards
    - Overlays, implant supported partial dentures and overdentures
    - The replacement of otherwise serviceable existing restorations and dental prosthetics
    - Precision attachments and stressbreakers

21. Dental services which the Plan determines not to be medically necessary or consistent with good professsional practice.

22. The provision of dental services which would not be consistent with the individual patient's dental needs and/or generally accepted professional standards of dental therapeutics for that patient.

23. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce

the likelihood of needing a more invasive surgery and/or experiencing post-operative complications.

24. Adjunctive dental services that are performed only to allow or facilitate the performance of another non-covered dental service.

25. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaws or related joints are not covered by specialized dental health plans. Requests for such services should be submitted to the Member's full service medical health plan.

26. Liability insurance cases: Dental care which is covered under automobile, medical, no-fault or similar type insurance is not covered.

EXHIBIT D

ORTHODONTICS (BRACES)

To take advantage of the PD Managed Care Orthodontic Benefit, a Member must:

- Be eligible;
- Be a group Member whose benefit package does not include indemnity orthodontics, (they would automatically be eligible for the standard pre-paid orthodontic benefit).
- Not be subject to any listed exclusion for orthodontic coverage.
- Have written prior approval by PD for referral to a contracted PD orthodontist.

    - ◊ A referral must be submitted to and approved by PD. This will authorize the Member to receive covered orthodontic services by a contracted PD orthodontist, who has agreed to provide these services at reduced fees for PD Members with an approved referral request.
    - ◊ Without prior approval by PD for an orthodontic referral request, the orthodontist is free to charge the Member his UCR, instead of the reduced fees listed in this booklet.

PD Orthodontic Benefits include:

1. Start up services including:

    - Cephalometric/Panographic radiographs
    - All needed tracings
    - All diagnostic/study models
    - All photographs
    - All case studies

Member copayment - $250.
(Services performed by outside laboratories are not a benefit; therefore the cost is entirely the Member's responsibility.)

2. All treatment performed during a 24 month* period including:

    - Consultations and all office visits.
    - All needed fixed and/or removable appliances (including headgear) required to adequately complete treatment in a satisfactory manner.
    - Banding
    - Retention, if required within 24 month covered treatment period.

Member copayment - See enclosed benefit schedule for your plan

*If orthodontic treatment requires more than 24 months, Members may be charged the orthodontist's regular fees for additional monthly visits as needed, as well as, copayments for retention (see item #3 below).

3. Retention is included in the full treatment copayment if started during the 24 month active treatment coverage period. If retention is begun after the 24 month treatment period, then an additional retention copayment is applicable.

Member copayment - $250. up to age 18 (includes upper and lower retainers).
Member copayment - $300 for adults (age 18 and older)

4. Final Records are covered if required by your orthodontist, including photographs, models, radiographs or other studies.

Member copayment - $150.
(Services performed by outside laboratories are not a benefit; therefore the cost is entirely the Member's responsibility.)

5. The following are not covered orthodontic benefits:

   - Lost, stolen, or broken appliances
   - Treatment in progress prior to effective date of PD coverage
   - Extractions required for orthodontic purposes
   - Surgical orthodontics or jaw repositioning
   - Myofunctional therapy
   - Cleft palate
   - Micrognathia
   - Macroglossia
   - Hormonal imbalances
   - Orthodontic retreatment
   - Interceptive orthodontics (see item #10 below.)

6. There is no age restriction for the orthodontic benefit. If a treatment plan is for less than 24 months, then a prorated portion of the full Member copayment shall apply.

7. If Member's dental eligibility ends, for whatever reason, and the Member is receiving orthodontic treatment under the Plan, the rest of the cost for that treatment will be prorated - at the orthodontist's UCR - over the number of months of treatment remaining. Member will be responsible for the payment of this balance under the terms and conditions Member has pre-arranged with the orthodontist.

8. If Member has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forego the treatment program, Member will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist.

9. One orthodontic treatment plan per lifetime is covered.

10. Active appliances, fabricated prior to full orthodontic treatment in an effort to prevent the need for orthodontic care, are not benefits of PD.

EXHIBIT E

PREPAYMENT FEES

A. The Organization and the Plan hereby agree that the Plan shall provide the services to Members of the Organization as indicated at the monthly fee of:

The premium rates for the plan year of: December 01, 2004 through November 30, 2006 are:

Subscriber	$ 42.60
Subscriber + Spouse	$ 42.60
Family	$ 42.60

B. The Organization shall pay the Company the sums indicated above on the 20th day of the month for each month this Agreement is in effect, commencing on the first day. Payment shall be paid by the 20th of the month prior to the month of coverage.

C. Payment of the monthly periodic fees indicated above, which shall be sent to Company, shall be paid by the Organization. The Members shall pay all fees, co-payments and excluded procedures, directly to the Professional Provider.

COMMENCEMENT OF BENEFIT AND WAITING PERIOD

BENEFIT shall commence on the first day of the month for all Members enrolled when the Plan begins. If a waiting period is indicated, BENEFIT shall commence on the first day of the month following a collection of one month's premium.

PACIFICARE DENTAL
Amendment

Issued To: The City of Long Beach Group ID: 11104

Original Effective Date: August 1, 1987

The above mentioned Subscriber Agreement is hereby amended to include definition of eligible dependents as follows:

1. Amendment. Pursuant to the benefits set forth in the Agreement are hereby amended as follows:

SECTION 1. DEFINITIONS

1.05 Definition of Dependent is amended to read as follows:

1.05 Dependent is any spouse, Same Gender Domestic Partner (as defined below), or unmarried child (including a stepchild or adopted child) of Subscriber who is enrolled hereunder, who meets all the eligibility requirements set forth in Paragraph 2.03 and for whom applicable Health Plan Premiums are received by PacifiCare.

1.05(a) Eligible Dependent is the Subscriber's spouse, Same Gender Domestic Partner and the unmarried dependent children of the Subscriber, Subscriber's spouse or Same Gender Domestic Partner who works or resides within the Service Area and who is eligible for Enrollment as a Dependent in the Health Plan as determined by the City of Long Beach. Eligible Dependents are:

(i) The natural born or legally adopted children of the Subscriber or of the Subscriber's spouse (i.e. stepchildren) or Same Gender Domestic Partner;
(ii) Children for whom the Subscriber, Subscriber's spouse or Same Gender Domestic Partner has been appointed a legal guardian by a court and of which there had been a foster child relationship; and
(iii) Children for whom the Subscriber, Subscriber's spouse or Same Gender Domestic Partner is required to provide health coverage pursuant to a qualified medical support order.

1.05(b) Definition of Same Gender Domestic Partner is added to read as follows:

1.05(b) Same Gender Domestic Partner is defined as an adult of the same gender who shares an emotional, physical and financial relationship with the employee, similar to that of a spouse. To be eligible for domestic partner coverage under the Group's employee benefits plans, the employee and domestic partner must complete the Affidavit of Domestic Partnership, in which each person individually certifies to the following facts:

- Each person is age 18 or older.
- Neither party may be currently married to another party. Proof of final decree of divorce may be required.
- Neither may be related to the other and are not related by blood closer than would prohibit legal marriage such as a parent, brother or sister, half brother or sister, niece, nephew, aunt uncle, grandparent or grandchild. Domestic Partnership does not include roommates, friends or other similar relationships.
- Neither party has a different domestic partner now, nor has had a different domestic partner within the last six months after the effective date of coverage, unless a previous domestic partnership terminated by death.
- Both partners reside together and intend to do so indefinitely.
- Both partners agree to be economically responsible to third parties for their common welfare and financial obligations incurred during the period covered by the Group employer Health Plan. Examples include joint contribution for food, shelter and living expenses.
- Each domestic partner must be a citizen of the United States or an immigrant who has been lawfully admitted for permanent residence in the United States in accordance with the United States immigration laws.

1.06 Definition of Eligible Employee is amended to read as follows:

1.06 Eligible Employee is a permanent full-time City of Long Beach employee that is working a minimum of 40 hours per week and meets the applicable waiting period required by the City of Long Beach as follows:

a. New employee's hired on the 1st through the 4th of the month are eligible on the first of the following month;
b. New employee's hired on or following the 5th of the month are eligible on the first of the month following 30 days employment;

Additionally, an Eligible Employee is:

c. Defined as an employee under state and federal law;
d. Actively working or is able to return to active work and has certain rights pertaining to leaves of absence if his or her condition improves. Consultants, temporary labor, suppliers or contractors are not Eligible Employees.

SECTION 3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENTS

Section 3.07. 01 Modification of Health Plan Premium Rates is hereby amended to read as follows:

3.07.01 Modification of Health Plan Premium Rates. The City of Long Beach's premium rates are guaranteed for the twelve (12) month period that this agreement is in force.

Notwithstanding the above, if the State of California or any other taxing authority imposes upon PacifiCare a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by PacifiCare's gross receipts or any portions of either, then upon thirty (30) days written notice to Group, Group shall remit to PacifiCare with the appropriate payment, a pro rata amount sufficient to cover all such taxes and license fees rounded to the nearest cent.

SECTION 7. TERMINATION OF GROUP COVERAGE

Section 7.02.04 For Ceasing to Meet Group Eligibility Criteria is hereby deleted.

SECTION 8. MISCELLANEIOUS PROVISIONS

Section 8.12 Acceptance of Agreement is hereby amended to read as follows:

Section 8.12 Acceptance of Agreement Group may accept this Agreement only by execution of the agreement. Such acceptance shall render all terms and provisions of this Agreement binding on PacifiCare, Group and Members.

Section 8.17 Death of Retiree Subscriber, (Dependent Eligibility), shall be added to read as follows:

Section 8.17 Death of Retiree Subscriber, Survivor Benefits. In the event of the Subscriber who elects or elected, upon retirement, to convert sick leave credits to a cash equivalency to pay health and dental insurance plan premiums or both, following retirement, any accumulated cash equivalency unused at the time of the death of Subscriber may be utilized for the purpose of continuing payment by the City of Long Beach of the health and dental insurance plan premiums for the spouse and eligible dependents provided that:

(1) The Subscriber has an effective retirement date of July 1, 1983 or later; or
(2) The Subscriber did not predecease the surviving eligible dependent prior

to July 1, 1983;

The payment of the premiums shall continue until any of the following:

(i) There is an insufficient cash equivalency to pay the required monthly premiums as determined by Group; or

(ii) In the case of a surviving spouse, the spouse remarries; or

(iii) In the case of a dependent child, the child reaches the age of 19 or is no longer a full-time student in an accredited educational institution as recognized by PacifiCare.

(iv) In the case of a surviving spouse, the spouse becomes eligible for Medicare during a period of premium eligibility under this Section. In that case, premium payment may be adjusted to pay for the Medicare Supplement plan in accordance with the provisions of Subsection 2.11 of Article Two of City of Long Beach Ordinance No. C-3548.

2. Effect of this Amendment. The Amendment shall not be further amended, modified or revised and the Agreement shall continue in full force and effect and shall be enforced in accordance with its terms and conditions. **This amendment shall expire on November 30, 2005. IN WITNESS WHEREOF, the parties hereto have executed this Agreement in Cypress, California, on October 30th, 2003.**

This Amendment does not change, waive, or extend any part of the Subscriber Agreement to which it is attached except as set forth above. This Amendment terminates concurrently with the Subscriber Agreement to which it is attached.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in Santa Ana, California, on [June 30, 2005].

PACIFICARE DENTAL

BY _____

John W. Whalley
Vice President, Mid-Market Sales and Service

PACIFICARE DENTALAND VISION ADMINISTRATORS

BY _____

Kelly McCrann
President

APPROVED AS TO FORM
12/30, 2005
ROBERT E SHANNON, City Attorney
BY _____
SENIOR DEPUTY CITY ATTORNEY

CITY OF LONG BEACH

BY _____

Name: Gerald R. Miller

Title: City Manager

State of California
City of Long Beach

On June 30], 2005 before me, [Patricia Sanders], personally appeared John W. Whalley, Vice President, Mid-Market Sales and Service and Kelly McCrann, Presiden..

[✓] proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) ~~is~~/are subscribed to the within instrument and acknowledge to me that ~~he/she~~/they executed the same in ~~his/her~~ their authorized capacity(ies), and that by ~~his/her~~/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____
Patricia Sanders, Notary Public

PATRICIA SANDERS
Comm. # 1353491
NOTARY PUBLIC - CALIFORNIA
Los Angeles County
My Comm. Expires April 25, 2006

ALL-PURPOSE ACKNOWLEDGEMENT

State of California
County of Orange } SS.

On 1-31-05 (DATE) before me, Patricia Sanders (NOTARY),
personally appeared John Whalley and Chris Boles (SIGNER(S))

☐ personally known to me - OR - ☒ proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) ~~is~~/are subscribed to the within instrument and acknowledged to me that ~~he/she~~/they executed the same in ~~his/her~~/their authorized capacity(ies), and that by ~~his/her~~/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

PATRICIA SANDERS
Comm. # 1353491
NOTARY PUBLIC - CALIFORNIA
Los Angeles County
My Comm. Expires April 25, 2006

WITNESS my hand and official seal.

Patricia Sanders
NOTARY'S SIGNATURE

OPTIONAL INFORMATION

The information below is not required by law. However, it could prevent fraudulent attachment of this acknowledgement to an unauthorized document.

CAPACITY CLAIMED BY SIGNER (PRINCIPAL)

☐ INDIVIDUAL
☒ CORPORATE OFFICER
VP CFO
TITLE(S)
☐ PARTNER(S)
☐ ATTORNEY-IN-FACT
☐ TRUSTEE(S)
☐ GUARDIAN/CONSERVATOR
☐ OTHER: _____

DESCRIPTION OF ATTACHED DOCUMENT

_____
TITLE OR TYPE OF DOCUMENT

_____
NUMBER OF PAGES

_____
DATE OF DOCUMENT

_____
OTHER

SIGNER IS REPRESENTING:
NAME OF PERSON(S) OR ENTITY(IES)

RIGHT THUMBPRINT OF SIGNER

Top of thumbprint here