LOS ANGELES POLICE RELIEF ASSOCIATION, INC.

July 1, 2020

PPO Dental Blue Complete Plan Benefit Booklet

Dear Plan Member:

This Benefit Booklet provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Subscribers and covered dependents ("members") are referred to in this booklet as "you" and "your". The *plan administrator* is referred to as "we", "us" and "our".

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this booklet.

Please read this Benefit Booklet ("*benefit booklet*") carefully so that you understand all the benefits your *plan* offers. Keep this Benefit Booklet handy in case you have any questions about your coverage.

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the *plan administrator* who is responsible for their payment. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21215 Burbank Blvd., Woodland Hills, CA 91367 marked to the attention of the Member Services Department named on your identification card). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

All grievances received under the *plan* will be acknowledged in writing, together with a description of how the *plan* proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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TYPES OF PROVIDERS

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

You do not have to select a particular *dentist* to receive dental benefits. You have the freedom to choose the *dentist* you want to utilize to access *covered services*. **However, he *maximum allowed amount* may vary depending upon whether the *dentist* is a *Network* or a *non-Network provider*.**

Network Dentists. The *claims administrator* has established a network of various types of participating providers. These *dentists* are called "*network providers*" because they have agreed to participate in the network. They have agreed to a rate they will accept as reimbursement for *covered services*.

All dentists participating in the Anthem Blue Cross Dental Blue Complete Network 100, 200 or 300 are considered network providers under the LAPRA PPO Dental Plan.*

To find a *network provider*, please access the *claims administrator*'s web site at www.anthem.com/ca or call the Member Services Department at (866) 527-5801.

Non-network Dentists. *Non-network providers* are *providers* who have not signed any contract and are not in the preferred provider organization network. The *maximum allowed amount* payable under this *plan* will be different for *non-network providers* than for *network providers*.

*Exception: In Idaho, all dentists participating in the Anthem Blue Cross PPO Network are considered Network providers under the LAPRA PPO Dental Plan.

SUMMARY OF BENEFITS

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

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

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

The benefits of this *plan* may be subject to the SUBROGATION AND REIMBURSEMENT section.

DENTAL BENEFITS

DENTAL DEDUCTIBLES (per *calendar year*)

Non-Network Providers

- Member Deductible.....**$25**
- Family Deductible **$50**

Exception: The Dental Deductible does not apply to services provided by a *Network dentist* or to Diagnostic and Preventive Services provided by a *non-Network dentist*.

PAYMENT RATES

After any applicable Dental Deductible has been satisfied, the plan will pay the percentage of the m*aximum allowed amount* shown below, for the type of services received, up to the Dental Benefit Maximums:

Exception: For residents of Montana, *all* claims will be paid at the *payment rates* shown below for NETWORK providers.

Network Providers

- Diagnostic & Preventive Services.....**100%**
- Minor Restorative Services.....**90%**
- Prosthodontic Services.....**60%**

- Endodontic Services **90%**
- Periodontal Services **90%**
- Oral Surgery **90%**
- Orthodontic Services **50%**

Non-Network Providers

- Diagnostic & Preventive Services **100%**
- Minor Restorative Services **80%**
- Prosthodontic Services **60%**
- Endodontic Services **80%**
- Periodontic Services **80%**
- Oral Surgery **80%**
- Orthodontic Services **50%**

DENTAL BENEFIT MAXIMUMS

- Calendar Year Maximum **$2,000**
- Orthodontic Lifetime Maximum **$1,750**

YOUR DENTAL BENEFITS

The *plan* will pay the *maximum allowed amount* for covered dental charges you incur, subject to all the terms, conditions, limitations and exclusions specified in this *benefit booklet*.

HOW MAXIMUM ALLOWED AMOUNT IS DETERMINED

This section describes how the amount of reimbursement for covered services or supplies is determined. Reimbursement for dental services rendered by *Network* and *non-Network dentists* is based on this *plan's maximum allowed amount* for the covered service or supply you receive.

The m*aximum allowed amount* is the maximum amount of reimbursement the *plan* will allow for services and supplies:

- That meet the requirements under YOUR DENTAL BENEFITS, to the extent such services and supplies are covered under your *plan* and are not excluded;
- That are *medically necessary*; and
- That are provided in accordance with all applicable utilization review or other requirements set forth in your *plan*.

Network dentists have agreed not to charge you more than the *maximum allowed amount*. When you choose a *Network dentist*, you will not be responsible for any amount in excess of the *maximum allowed amount* for the covered services of a *Network provider.*

Your share of the cost of your dental care may be greater if you choose a *non-Network provider*. You will be responsible for any billed charge which exceeds *maximum allowed amount* for services provided by a *non-Network provider.*

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

DENTAL DEDUCTIBLES, HOW DENTAL BENEFITS ARE PAID AND DENTAL BENEFIT MAXIMUMS

After the Dental Deductible is subtracted from the total *maximum allowed*

amount, the plan will pay benefits which apply to such expense, up to the applicable Dental Benefit Maximums. The Deductible amount, Benefits, and Dental Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DENTAL DEDUCTIBLES

Only charges for *covered services* will apply toward satisfaction of the Dental Deductible.

Member Deductible. Each *calendar year*, you will be responsible for satisfying the Member Deductible for *non-Network providers* before benefits are paid under the *plan*.

Family Deductible. If enrolled members of a family pay Deductible expense during a *calendar year*, equal to the Family Deductible amount for *non-Network providers* shown in the SUMMARY OF BENEFITS, then the Dental Deductible for all members is considered to have been met. No further Dental Deductible is required for the remainder of the *year*.

Dental Deductible Carryover Provision. If your dental deductible for *non-Network providers* is not met in a given *calendar year*, covered dental charges incurred for *non-Network providers* from October through December and applied toward the *non-Network calendar year* dental deductible for that *calendar year* will also be applied to your *non-Network* dental deductible for the next *calendar year*. If your *non-Network* dental deductible is satisfied in a given *calendar year*, any amount applied toward that *calendar year* dental deductible for *non-Network providers* will not carry over to the next *calendar year's non-Network* dental deductible.

Prior LAPRA PPO Plan Dental Deductibles. If you were covered for dental benefits under LAPRA's prior CIGNA PPO Dental *plan*, any amount paid for dental benefits for the services of *non-Network providers* during the same *calendar year* toward your dental deductible for *non-Network providers* under the *prior plan* will be applied toward your Dental Deductible for *non-Network providers* under this *plan*; provided that, such payments were for *covered services* under this *plan*.

HOW DENTAL BENEFITS ARE PAID

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY SO YOU WILL KNOW HOW COVERED DENTAL CARE WILL BE REIMBURSED.

***NETWORK Providers*.** A *Network provider* is a provider who is in the network for this *plan* or who has a participation contract with the *claims administrator*. For covered services performed by a *Network provider*, the *maximum allowed amount* for your *plan* is the rate the provider has agreed with the *claims administrator* to accept as reimbursement for the covered services. Because participating providers have agreed to accept the

maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the *maximum allowed amount*. However, you may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent you have not met your deductible, or have *coinsurance*. You will normally receive the greatest level of benefits available for *covered services* under this *plan* when you seek treatment from a Dental Blue 100 *Network provider*.

Please refer to your identification card to verify that you are a member of the Dental Blue Complete PPO Plan. If you are uncertain which *NETWORK providers* will provide you with the lowest out-of-pocket expense, please contact Member Services at the toll-free number indicated on your identification card or visit online at www.anthem.com/ca.

***Non-Network Providers*.** Providers who have not signed any contract with the *claims administrator* and are not in any of the *claims administrator*'s networks are *non-Network providers.* For covered services you receive from a *non-Network provider,* the *maximum allowed amount* for this *plan* will be one of the following: The protected balance billing feature does **not** apply to services provided by *non-Network providers*.

1. An amount based on our *non-participating provider* fee schedule, which the *claims administrator* has established, and which may be modified from time to time, after considering some or all of the following: record fee data, reimbursement amounts accepted by like or similar providers contracted with Dental Blue 100, reimbursement amounts accepted by like or similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or

2. An amount based on information provided by a third party vendor, which reflects providers' charges for delivering care, or

3. An amount negotiated by the *claims administrator* or a third party vendor which has been agreed to by the provider; or

4. An amount equal to the total charges billed by the provider, but only if such charges are less than the *maximum allowed amount* calculated by using one of the methods described above.

Unlike *participating providers*, *non-Network providers* may send you a bill and collect for the amount of the *non-Network provider's* charge that exceeds the *maximum allowed amount*. You are responsible for paying the difference between the *maximum allowed amount* and the amount the *non-Network provider* charges. This amount can be significant. Choosing a *Network provider* will likely result in lower out of pocket costs to you. Please call the Member Services number on your ID card for help in finding a *Network provider* or visit the *claims administrator*'s website at www.anthem.com/ca.

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

SUMMARY OF COSTS

If you receive treatment from a Dental Blue Complete PPO *Provider:*

- Payment rates will be based on the *Network provider* percentages listed in the SUMMARY OF BENEFITS.
- You are responsible for any *coinsurance*, dental deductibles, non-covered services, and any amounts over the dental benefit maximums as outlined in the SUMMARY OF BENEFITS.

If you receive treatment from a *non-Network provider:*

- Payment rates will be based on the *non-Network provider* percentages listed in the SUMMARY OF BENEFITS.
- You are responsible for any *coinsurance*, dental deductibles, non-covered services, and any amounts over the dental benefit maximums as outlined in the SUMMARY OF BENEFITS PLUS any amount which exceeds the covered expense.

DENTAL BENEFIT MAXIMUMS

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

Orthodontic Lifetime Maximum. Your orthodontic benefits are subject to the Orthodontic Lifetime Maximum shown in the SUMMARY OF BENEFITS. The *plan* will not pay any orthodontic benefits in excess of that amount during a *member's* lifetime.

Prior Plan Maximum Benefits. The amount of any benefits paid to you under LAPRA's prior CIGNA PPO plan will reduce any maximum amounts for which you are eligible under this *plan* which apply to the same benefit.

DENTAL BENEFITS EXTENSION

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

DENTAL UTILIZATION REVIEW

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

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

PRE-TREATMENT REVIEW

You may have a pre-treatment review done before you receive benefits. “Pre-treatment review” is not a prior authorization for services but is a system that allows you and your *dentist* to know, in advance, what the estimated benefits payable would be under this *plan* for a proposed course of treatment. The actual benefits you receive under the *plan* will be determined once a claim for services has been received and may vary

from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

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

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

RETROSPECTIVE REVIEW

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

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

If you disagree with a utilization review decision and wish to file a grievance or appeal a decision previously made, you may contact Member Services at the toll-free number on your identification card.

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

DENTAL CARE THAT IS COVERED

This section describes the *covered services* available under your dental care benefits when provided and billed by *providers*. All *covered services* are subject to the terms, limitations and exclusions stated in this *plan*, including dental benefit maximums. The *maximum allowed amount* payable for *covered services* varies depending on whether you receive your care from a *NETWORK provider* or a *non-Network provider.*

Diagnostic and Preventive

- Clinical oral examination, and/or consultation, and/or office visit during regular hours – Up to 2 per person per calendar year.

  Limited to two per *year* in any combination of the following types of evaluations: periodic, limited, comprehensive, periodontal, consultation, and office visits for observation only. Office visits for observation are not covered when performed in conjunction with other services or procedures. Limited emergency examinations are covered as a separate procedure only if no other service, other than x-rays, is performed on the same date of service.

- Palliative (emergency) treatment of dental pain, minor procedures. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

- X-rays – Complete series – One per person, including panoramic film, in any 3 calendar years.

- Bitewing x-rays – Two charges per person per calendar year.

- Panoramic (Panorex) x-ray – One per person, including full-mouth x-rays, in any 3 calendar years.

- Prophylaxis (Cleaning) – Three per person per calendar year, singly or in combination with periodontal maintenance procedures.

- Periodontal maintenance procedures – Three per person per calendar year, singly or in combination with routine prophylaxis. Covered only when following active periodontal therapy.

- Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. One per person per calendar year.

- Topical application of sealant, per tooth, on first and second molars for a person less than 14 years old – One treatment per tooth in any 3 calendar years, for permanent unrestored teeth only.

- Space Maintainers, fixed unilateral, fixed-bilateral and removable unilateral and bilateral – Limited to non-orthodontic treatment.

Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

- Amalgam Filling – once per surface per tooth per 24 months.
- Composite/Resin Filling – once per surface per tooth per 24 months.
- Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.
- Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.
- Periodontal Scaling and Root Planing. Entire Mouth
- Adjustments – Complete Denture

  Any adjustment of or repair to a denture within six months of its installation is not a separate Dental Service.
- Recement Bridge
- Routine Extractions
- Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

  Removal of Impacted Tooth, Soft Tissue
  Removal of Impacted Tooth, Partially Bony
  Removal of Impacted Tooth, Completely Bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by the *plan administrator*, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- IV. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by the *plan administrator*, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Prosthodontic Services

- Crowns

  Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  Porcelain Fused to High Noble Metal

  Full Cast, High Noble Metal

  Three-Fourths Cast, Metallic

- Removable Appliances

  Complete (Full) Dentures, Upper or Lower

  Partial Dentures

  Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

  Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

- Fixed Appliances

  Bridge Pontics - Cast High Noble Metal

  Bridge Pontics - Porcelain Fused to High Noble Metal

  Bridge Pontics - Resin with High Noble Metal

  Retainer Crowns - Resin with High Noble Metal

  Retainer Crowns - Porcelain Fused to High Noble Metal

  Retainer Crowns - Full Cast High Noble Metal

- Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

- Implants

  Surgical placement of implants

  Implant abutment

  Implant/abutment supported crown

Orthodontics

- Each month of active treatment is a separate Dental Service.

  Covered Expenses include:

  Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment, including all active treatment and retention appliances.

  Continued active treatment after the first month.

  Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for Orthodontics during a person's lifetime will not be more than the Orthodontia Maximum shown in the SUMMARY OF BENEFITS.

Payments for comprehensive full-banded Orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Enhanced Benefits

Enhanced dental benefits are available for *members* who are pregnant or diagnosed with Type 1 or Type 2 diabetes. *Members* diagnosed with gestational diabetes are eligible for benefits due to pregnancy or diabetes, but not both.

A *member* who is pregnant or diagnosed with gestational diabetes is eligible for one additional benefit for a maximum of two *calendar years*. A *member* diagnosed with Type 1 or Type 2 diabetes is eligible for one additional benefit per *calendar year* until their coverage with the *plan* terminates. The enhanced benefits include a maximum of one of the following procedures:

- Prophylaxis-adult
- Prophylaxis-child
- Periodontal maintenance. Covered only when following active periodontal therapy.

To obtain the additional benefit(s), the *member* must complete the enhanced benefit enrollment form and submit it to the *claims administrator* at:

Anthem Blue Cross Life and Health

233 S. Wacker Drive

Suite 3700

Chicago, IL. 60606

Attention: Clinical Integration Coordinator

The enhanced benefit(s) will be available on the first of the month following the date the *claims administrator* receives the enhanced benefit enrollment form.

It is important to note that the enhanced benefit(s) will not count toward the Dental Benefit Maximum.

Pulp capping / pulp therapy / root canal therapy:

Pulp capping / pulp therapy: Limited to once per tooth during lifetime

Root canal therapy: Limited to once per tooth and one retreatment for the same tooth during lifetime.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service.

Therefore, the *plan administrator* recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by *plan administrator*'s dental

consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Plan Administrator will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, *plan administrator* will determine covered dental expenses when it receives a claim.

DENTAL CARE THAT IS NOT COVERED

Covered Expenses will not include, and no payment will be made for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- bite registrations; precision or semiprecision attachments; or splinting;instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- services received for Implants, except as stated under DENTAL CARE THAT IS COVERED, including, but not limited to, initial installation of an implant, full or partial dentures or fixed bridgework to replace a tooth which was extracted prior to becoming an *insured person* under this *plan. C*overage for congenitally missing teeth. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments. Implant maintenance or repair to an implant or implant abutment. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of

implants.

- services for which benefits are not payable according to the "General Limitations" section.

SCHEDULE OF NON-COVERED SERVICES

No payment will be made under YOUR DENTAL BENEFITS for expense incurred for, or in connection with, any of the services below. Notice that for each service listed in the Schedule, there is a "Procedure Code". *Dentists* use these Procedure Codes to identify their services for billing purposes. These codes are published by the American Dental Association and are widely used throughout the dental profession.

Diagnostic

PROC CODE	DENTAL PROCEDURE
D0290	Posterior-anterior and facial bone survey film
D0310	Sialography
D0320	Temporomandibular joint arthrogram, with injection
D0321	Other temporomandibular joint films
D0322	Tomographic survey
D0360	Cone beam ct - craniofacial data capture
D0362	Cone beam - two-dimensional image reconstruction using existing data, includes multiple images
D0363	Cone beam - three-dimensional image reconstruction using existing data, includes multiple images
D0416	Viral Culture
D0421	Genetic Test for Susceptibility to oral diseases
D0425	Caries susceptibility tests
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures
D0460	Pulp vitality tests
D0475	Decalcification procedure
D0476	Special stains for microorganisms
D0477	Special stains, not for microorganisms
D0478	Immunohistochemical stains

D0479	Tissue in-situ hybridization, including interpretation
D0480	Processing & interpretation of cytologic smears including written report
D0481	Electon microscopy - diagnostic
D0482	Direct immunofluorescence
D0483	Indirect immunofluorescence
D0484	Consultation on slides prepared elsewhere
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source

Preventive

PROC CODE	DENTAL PROCEDURE
D1310	Dietary planning for the control of dental caries
D1320	Tobacco counseling for the control of dental disease
D1330	Oral hygiene instructions

Restorative

PROC CODE	DENTAL PROCEDURE
D2955	Post removal, not in conjunction with endodontic therapy
D2960	Labial veneer, laminate/chairside
D2961	Labial veneer, resin laminate/laboratory
D2962	Labial veneer, porcelain laminate/laboratory
D2975	Coping

Periodontics

PROC CODE	DENTAL PROCEDURE
D4320	Provisional splinting-intracoronal
D4321	Provisional splinting-extracoronal

Removable Prosthodontics

PROC CODE	DENTAL PROCEDURE
D5862	Precision attachment
D5867	Replacement of precision attachment
D5875	Modification of removable prosthesis following implant surgery
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prothesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance
D5951	Feeding aid
D5952	Pediatric speech aid

D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint

Fixed Prosthodontics

PROC CODE	DENTAL PROCEDURE
D6920	Connector bar
D6940	Stress breaker
D6950	Precision attachment
D6985	Fixed Pediatric partial denture

Oral surgery

PROC CODE	DENTAL PROCEDURE
D7260	Oral antral fistula closure
D7287	Cytology sample collection (brush biopsy)
D7292	Surgical placement: temporary anchorage device [screw retained plate] requiring surgical flap
D7293	Surgical placement: temporary anchorage device requiring surgical flap
D7294	Surgical placement: temporary anchorage device without surgical flap

D7460	Removal of nonodontogenic cyst or tumor-lesion-dia. <= 1.25 cm
D7461	Removal of nonodontogenic cyst or tumor-lesion-dia. > 1.25 cm
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction-producing foreign bodies-musculoskeletal system
D7610	Maxilla - open reduction - teeth immobilized if present
D7620	Maxilla-closed reduction-teeth immobilized if present
D7630	Mandible - open reduction- teeth immobilized if present
D7640	Mandible-closed reduction-teeth immobilized if present
D7650	Malar and/or zygomatic arch-open reduction
D7660	Malar and/or zygomatic arch-closed reduction
D7670	Alveolus-stabilization of teeth, open reduction splinting
D7671	Alveolus, open reduction, may include stabilization of teeth
D7680	Facial bones-complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla-open reduction
D7720	Maxilla-closed reduction
D7730	Mandible-open reduction
D7740	Mandible-closed reduction
D7750	Malar and/or zygomatic arch-open reduction
D7760	Malar and/or zygomatic arch-closed reduction
D7770	Alveolus-stabilization of teeth, open reduction splinting
D7771	Alveolus, closed reduction, stabilization of teeth, compound fracture
D7780	Facial bones-complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia

D7840	Condylectomy-surgical removal all or portion of the mandibular condyle or a portion thereof (separate procedure)
D7850	Surgical discectomy with/without implant-excision of the intra-articular disc of a joint
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint Reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy
D7876	Arthroscopy - surgical: discectomy
D7877	Arthroscopy - surgical: debridement
D7880	Occlusal orthotic appliance
D7899	Unspecified TMD therapy, by report
D7910	Suture of recent small wounds up to 5cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin grafts
D7940	Osteoplasty
D7941	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7943	Osteotomy - segmented or buapical - per sextant or quadrant
D7944	Osteotomy - body of mandible
D7945	LeFort I (maxilla - total)
D7946	LeFort I (maxilla - segmented)

D7947	LeFort II or LeFort III - without bone graft
D7948	LeFort II or LeFort III - with bone graft
D7949	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones
D7953	Bone replacement graft for ridge preservation - per site
D7955	Repair of maxillofacial soft and hard tissue defect
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency Tracheotomy
D7991	Coronoidectomy
D7997	Appliance removal, includes removal of archbar
D7998	Intraoral placement of a fixation device not in conjunction with a fracture

Orthodontics

PROC CODE	DENTAL PROCEDURE
D8690	Orthodontic treatment
D8692	Replacement of lost or broken retainer
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers

Adjunctive General

PROC CODE	DENTAL PROCEDURE
D9210*	Local anesthesia not in conjunction with operative or surgical procedures
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia
D9230	Analgesia
D9410	House call

D9420	Hospital call
D9440	Office visit-after hours
D9450	Case presentation, detailed and extensive treatment planning
D9610	Therapeutic drug injections
D9612	Therapeutic parenteral drugs, two or more administrations, different medications
D9630	Other drugs and/or medications
D9920	Behavior management
D9941	Fabricated athletic guard
D9970	Enamal Microabrasion
D9971	Odontoplasty 1-2 teeth
D9972	External bleaching - per arch
D9973	External bleaching - per tooth
D9974	Internal bleaching - per tooth

* Considered as part of the submitted fee for the global surgical procedure.

GENERAL LIMITATIONS

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;

- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the SUMMARY OF BENEFITS;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the *plan* pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The *plan* has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The *plan* has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the *plan* to exercise the *plan*'s rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the *plan* to exercise its subrogation rights, the *plan* shall be entitled to deduct the amount the *plan* paid from any future benefits under the *plan*.

- The *plan* has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the *plan*.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the *plan*'s subrogation claim and any claim held by you, the *plan*'s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The *plan* is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *plan*.

Reimbursement

If you obtain a Recovery and the *plan* has not been repaid for the benefits the *plan* paid on your behalf, the *plan* shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the *plan* from any Recovery to the extent of benefits the *plan* paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the *plan* shall have a right of full recovery, in first priority, against any Recovery. Further, the *plan*'s rights will not be reduced due to your negligence.

- You and your legal representative must hold in trust for the *plan* the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the *plan* immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the *plan's* equitable lien applies is a *plan* asset

- Any Recovery you obtain must not be dissipated or disbursed until such time as the p*lan* has been repaid in accordance with these provisions.

- You must reimburse the *plan*, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *plan*.

- If you fail to repay the *plan*, the *plan* shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the *plan* has paid or the amount of your Recovery whichever is less, from any future benefit under the *plan* if:

    1. The amount the *plan* paid on your behalf is not repaid or otherwise recovered by the *plan*; or

    2. You fail to cooperate.

- In the event that you fail to disclose the amount of your settlement to the *plan*, the *plan* shall be entitled to deduct the amount of the *plan*'s lien from any future benefit under the *plan*.

- The *plan* shall also be entitled to recover any of the unsatisfied portion of the amount the *plan* has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the *plan* has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the *plan* will not have any obligation to pay the Provider or reimburse you.

- The *plan* is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the *plan* of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by the *plan*.

- You must cooperate with the *plan* in the investigation, settlement and protection of the *plan's* rights. In the event that you or your legal representative fail to do whatever is necessary to enable the *plan* to exercise its subrogation or reimbursement rights, the *plan* shall be entitled to deduct the amount the *plan* paid from any future benefits under the *plan*.

- You must not do anything to prejudice the *plan*'s rights.

- You must send the *plan* copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

- You must promptly notify the *plan* if you retain an attorney or if a lawsuit is filed on your behalf.

- You must immediately notify the *plan* if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The *Plan Administrator* has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this *plan* in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The *plan* is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The *plan* shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The *plan* shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

COORDINATION OF BENEFITS

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

DEFINITIONS

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for dental care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(3) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(4) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order Of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

   (a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

   (b) then, the Plan of the parent with custody of the child;

   (c) then, the Plan of the spouse of the parent with custody of the child;

   (d) then, the Plan of the parent not having custody of the child, and

   (e) finally, the Plan of the spouse of the parent not having custody of the child.

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. The *plan administrator* will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, the *plan administrator* will determine the following:

(1) the *plan administrator*'s obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, the *plan administrator* will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If the *plan administrator* pays charges for benefits that should have been paid by the Primary Plan, or if the *plan administrator* pays charges in excess of those for which we are obligated to provide under the Policy, the *plan administrator* will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

The *plan administrator* will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

The *plan administrator*, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

HOW COVERAGE BEGINS AND ENDS

Please contact a LAPRA Benefits Representative at (213) 674-3701 or (888) 252-7721 for information regarding Eligibility.

CONTINUATION OF COVERAGE

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

DEFINITIONS

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

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

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *plan* as either a *subscriber* or *dependent;* and (b) a *child* who is born to or placed for adoption with the *subscriber* during the COBRA continuation period. Qualified Beneficiary does not include: (a) any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a *domestic partner*, or a *child* of a *domestic partner*, if they are eligible.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the *plan*. These events are referred to throughout this section by number.

1. **For Subscribers and Dependents:**

    a. The *subscriber's* termination of employment, for any reason other than gross misconduct; or

    b. Loss of coverage under the employer's health plan due to a reduction in the *subscriber's* work hours.

2. **For Retired Employees and their Dependents.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *plan administrator's* filing for Chapter 11 bankruptcy, provided:

    a. The *plan* expressly includes coverage for retirees; and

b. Such cancellation or reduction of benefits occurs within one year before or after the *plan administrator's* filing for bankruptcy.

3. **For Dependents:**

   a. The death of the *subscriber*;

   b. The *spouse's* divorce or legal separation from the *subscriber;*

   c. The end of a *child's* status as a dependent *child*, as defined by the *plan;* or

   d. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *dependent*, **other than a *domestic partner,* and a *child* of a *domestic partner***, may choose to continue coverage under the *plan* if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. We will notify either the *subscriber* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *plan administrator* will notify the *subscriber* of the right to continue coverage.

2. For Qualifying Events 3(a) or 3(d) above, a *dependent* will be notified of the COBRA continuation right.

3. You must inform the *plan administrator* within 60 days of Qualifying Events 3(b) or 3(c) above if you wish to continue coverage. The *plan administrator* in turn will promptly give you official notice of the COBRA continuation right.

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

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

Notice of continued coverage, along with the initial required monthly contribution, must be delivered to us within 45 days after you elect COBRA continuation coverage.

Additional Dependents. A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *dependent*. The standard enrollment provisions of the *plan* apply to enrollees during the COBRA continuation period.

Cost of Coverage. You may be required to pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to the *plan administrator* each month during the COBRA continuation period.

Besides applying to the *subscriber,* the *subscriber's* required monthly contribution will also apply to:

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

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

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

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

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

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

For *dependents* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

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

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

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

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

4. The date the *plan* terminates;

5. The end of the period for which required monthly contributions are last paid;

6. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or

7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

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

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and

2. Be determined and certified to be so disabled by the Social Security Administration.

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

1. The date of the Social Security Administration's determination of the disability;

2. The date on which the original Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses coverage; or

4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

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

1. If the disabled *member* continues coverage during this extension, this rate shall be **150%** of the applicable rate for the length of time the disabled *member* remains covered, depending upon the number of covered *dependents*. If the disabled *member* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.

2. The cost for extended continuation coverage must be remitted to us each month during the period of extended continuation coverage. Timely payment of the required monthly contribution must be remitted to us in order to maintain the extended continuation coverage in force.

3. You may be required to pay the entire cost of the extended continuation coverage.

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

When The Extension Ends. This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

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

3. The date the *plan* terminates;

4. The end of the period for which required monthly contributions are last paid;

5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or

6. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

GENERAL PROVISIONS

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

Independent Contractors. The *claims administrator's* relationship with providers is that of an independent contractor. *Dentists and* other dental health professionals are not the *claims administrator's* agents nor is the *claims administrator* or any of the *claims administrator's* employees, an employee or agent of any dental group or dental care provider of any type.

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

Terms of Coverage

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

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

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

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the *plan*.

Free Choice of Provider. You may choose any dental care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

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

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

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

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

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

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

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

Timely Payment of Claims. Any benefits due under this *plan* shall be due once the *claims administrator* has received proper, written proof of loss, together with such reasonably necessary additional information the *plan* may require to determine its obligation.

Payment to Providers. The benefits of this *plan* will be paid directly to *NETWORK dentists*. Also, *non-Network dentists* will be paid directly when you assign benefits in writing. These payments will fulfill the *plan's* obligation to you for those covered services.

Right of Recovery. Whenever payment has been made in error, the *claims administrator* will have the right to make appropriate adjustment to claims, recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event the *claims administrator* recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, the *claims administrator* will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. The *claims administrator* reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if the *claims administrator* pays your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, the *claims administrator* may collect such amounts directly from you. You agree that the *claims administrator* has the right to recover such amounts from you.

The *claims administrator* has oversight responsibility for compliance with provider and vendor and subcontractor contracts. The *claims administrator* may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

The *claims administrator* has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. The *claims administrator* will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The *claims administrator* may not provide you with notice of overpayments made by them or you if the recovery method makes providing such notice administratively burdensome.

Liability to Pay Providers. In the event that the *plan* does not pay a provider who has provided benefits to you, you will be required to pay that provider any amounts not paid to them by the *plan*.

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

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

Financial Arrangements with Providers. The *claims administrator* or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its *members* and members entitled to health care benefits under individual certificates and group policies or contracts to which the *claims administrator* or an affiliate is a party, including all persons covered under the *plan*.

Under the above-referenced contracts between Providers and the *claims administrator* or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *plan* may differ from the rates paid for persons covered by other types of products or programs offered by the *claims administrator* or an affiliate for the same medical services. In negotiating the terms of the *plan*, the *plan administrator* was aware that the *claims administrator* or its affiliates offer several types of products and programs. The *subscribers*, *dependents*, and the *plan administrator* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *plan*.

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

You must be under the care of the *NETWORK dentist* at the time the *dentist's* contract terminates. The terminated *dentist* must agree in writing to provide services to you in accordance with the terms and conditions of

his or her agreement with the *claims administrator* prior to termination. The *dentist* must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the *claims administration* prior to termination. If the *dentist* does not agree with these contractual terms and conditions, the *dentist's* services will not be continued beyond the contract termination date.

Benefits will be provided for the completion of covered services by a terminated *dentist* only for the following conditions:

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another *dentist*, as determined by the *claims administrator* in consultation with you and the terminated *dentist* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the *dentist's* contract terminates.

3. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

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

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

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

You will be notified by telephone, and the *dentist* by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated *dentist's* are negotiated on a case-by-case basis. The terminated *dentist* will be asked to agree to accept reimbursement and contractual requirements that apply to *NETWORK dentists*, including payment terms. If the terminated *dentist* does not agree to accept the same reimbursement and contractual requirements, that *dentist's* services will be reimbursed at the non-Network level of benefits. If you disagree with our determination regarding continuity of care, you may file a complaint as described in the COMPLAINT NOTICE.

BINDING ARBITRATION

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

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

The *member* and the *plan administrator* agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

The *member* and the *plan administrator* agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class arbitrations, the *member* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *member*.

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

The arbitration is initiated by the *member* making written demand on the *plan administrator*. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration

entity, by agreement of the *member* and the *plan administrator*, or by order of the court, if the *member* and the *plan administrator* cannot agree.

DEFINITIONS

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

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

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

Benefit Booklet (benefit booklet) is this written description of the benefits provided under the *plan*.

Calendar year (year) is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

Child meets the *plan's* eligibility requirements for children as established by the *plan administrator*.

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the *plan.*

Coinsurance is the percentage of the *maximum allowed amount* which you are responsible to pay.

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

1. Within the scope of the license of the *provider* performing the service;
2. Rendered while coverage under this *plan* is in force;
3. Within the maximum *covered expense* amount;
4. *Medically necessary;*
5. Not specifically excluded or limited by the *plan*; and

6. Specifically included as a benefit within the *plan*.

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

Dependent (dependent) meets the *plan's* eligibility requirements for dependents as established by the *plan administrator*.

Domestic partner meets the *plan's* eligibility requirements for domestic partners as established by the *plan administrator*.

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

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

Maximum Allowed Amount is the maximum amount of reimbursement that the *plan* will allow for covered medical services and supplies under this *plan*. See YOUR DENTAL BENEFITS: HOW MAXIMUM ALLOWED AMOUNT IS DETERMINED.

Medically Necessary (Medical Necessity) procedures, services or treatments are those which are:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the dental condition;

2. Customarily provided for the prevention, diagnosis, or direct care and treatment of the dental condition;

3. In accordance with generally accepted standards of dental practice;

4. Not primarily for your convenience, or the convenience of your *dentist* or another provider; and

5. The least expensive covered service suitable for your dental condition according to generally accepted standards of dental practice.

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

Member is the *subscriber* or *dependent*. A member may enroll under only one dental plan provided by the *plan administrator*, or any of its affiliates.

NETWORK Provider is a *provider* who has entered into a contractual agreement or is otherwise engaged by the *claims administrator*, or with

another organization which has an agreement with the *claims administrator*, to provide *covered services* and certain administrative functions for one or more of the following three PPO networks: Dental Blue 100, Dental Blue 200, and/or Dental Blue 300. A directory of PPO providers is available on the *claims administrator's* website at www.anthem.com/ca, or you may call the *claims administrator* at the Member Services number listed on your identification card.

Non-Network Provider is a provider who has NOT entered into a contractual agreement with the *claims administrator* at the time services are rendered.

Plan is the set of benefits described in this *benefit booklet* and in the amendments to this *benefit booklet*, if any. This plan is subject to the terms and conditions of the *plan*. If changes are made to the plan, an amendment or revised *benefit booklet* will be issued to each *subscriber* affected by the change.

Plan administrator refers to LOS ANGELES POLICE RELIEF ASSOCIATION, INC., the entity to which is responsible for the administration of the *plan*.

Prior plan is a plan sponsored by us which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* effective date; and (3) had coverage terminate solely due to the prior plan's termination.

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

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

Spouse meets the *plan's* eligibility requirements for spouses as established by the *plan administrator*.

Subscriber is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *dependents*.

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

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

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

We (us, our) refers to LOS ANGELES POLICE RELIEF ASSOCIATION, INC.

You (your) refers to the *subscriber* and *dependents* who are enrolled for benefits under this *plan*.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك

للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

Hindi
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Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ
និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID
របស់អ្នកដើម្បីទទួលជំនួយ។(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html