Dental HMO Deluxe

(Available to groups of 101 and above)

Combined Evidence of Coverage and Disclosure Form

James Perse Enterprises, Inc.
Group Number: W0054268-D0000183
Effective Date: August 1, 2021

Evidence of Coverage

Blue Shield of California
Dental HMO Deluxe

NOTICE

This Evidence of Coverage booklet describes the terms and conditions of coverage of your Blue Shield of California (Blue Shield) dental Plan. It is your right to view the Evidence of Coverage prior to enrollment.

Please read this Evidence of Coverage carefully and completely so that you understand which services are covered and the terms and conditions that apply to your Plan. If you or your Dependents have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

At the time of your enrollment, Blue Shield of California provides you with a Matrix summarizing key elements of the Blue Shield of California Group Health Plan you are being offered. This is to assist you in comparing group health plans available to you.

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Member Services at the address or telephone number listed in the Member Services paragraphs of the Other Provisions section of this booklet.

IMPORTANT

No person has the right to receive the Benefits of this Plan for services or supplies furnished following termination of coverage, except as specifically provided under, when applicable, the Group Continuation Coverage provision in this booklet.

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

Benefits may be modified during the term of this Plan as specifically provided under the terms of the group contract or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.

IMPORTANT

If you opt to receive dental services that are not Covered Services under this Plan, a participating Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient 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 dental coverage options, you may call Member Services at 1-888-702-4171 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.

TABLE OF CONTENTS

SUMMARY OF BENEFITS 4

I. INTRODUCTION TO THE BLUE SHIELD DENTAL HMO PLAN 17

II. EVIDENCE OF COVERAGE STATEMENT 17

III. CHOICE OF DENTAL PROVIDER 17

- SELECTING A DENTAL PROVIDER 17
- CHANGING DENTAL PROVIDERS 17
- CONTINUITY OF CARE BY A TERMINATED PROVIDER 18
- CONTINUITY OF CARE FOR NEW MEMBERS BY NON-CONTRACTING PROVIDERS 18
- PAYMENT OF PROVIDERS 18
- RELATIONSHIP WITH YOUR DENTAL PROVIDER 18

IV. HOW TO USE YOUR DENTAL PLAN 18

- USE OF DENTAL PROVIDER 18
- REFERRAL TO PLAN SPECIALISTS 19
- EMERGENCY SERVICES 19
- OUT-OF-AREA BENEFITS 19
- IN-AREA BENEFITS (THOSE RECEIVED WITHIN THE SERVICE AREA) 20
- LIMITATION OF MEMBER LIABILITY 20
- RESPONSIBILITY FOR COPAYMENTS, CHARGES FOR NON-COVERED SERVICES, AND EMERGENCY CLAIMS 20
- BLUE SHIELD ONLINE 21

V. PLAN BENEFITS 21

- IMPORTANT INFORMATION 21
- MEMBER MAXIMUM LIFETIME BENEFITS 21

VI. GENERAL EXCLUSIONS AND LIMITATIONS 21

- GENERAL EXCLUSIONS 21
- ORTHODONTIC EXCLUSIONS 23
- MEDICAL NECESSITY EXCLUSION 23
- LIMITATIONS 23

VII. SERVICE AREA AND ELIGIBILITY 25

- SERVICE AREA 25
- ELIGIBILITY 25
- EFFECTIVE DATE OF COVERAGE 26
- PREPAYMENT FEE 26

VIII. DUPLICATE COVERAGE, REDUCTIONS - THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS 27

- LIMITATIONS FOR DUPLICATE COVERAGE 27
- EXCEPTION FOR OTHER COVERAGE 27
- CLAIMS AND SERVICES REVIEW 27
- REDUCTIONS - THIRD PARTY LIABILITY 27
- COORDINATION OF BENEFITS 28

IX. GROUP CONTINUATION COVERAGE 29

- GROUP CONTINUATION COVERAGE 29
- QUALIFYING EVENT 29
- NOTIFICATION OF A QUALIFYING EVENT 30
- DURATION AND EXTENSION OF CONTINUATION OF GROUP COVERAGE 30
- NOTIFICATION REQUIREMENTS 31
- PAYMENT OF DUES 31
- EFFECTIVE DATE OF THE CONTINUATION OF COVERAGE 31
- TERMINATION OF CONTINUATION OF GROUP COVERAGE 31
- CONTINUATION OF GROUP COVERAGE FOR MEMBERS ON MILITARY LEAVE 32

X. TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS 32

- TERMINATION OF BENEFITS 32
- REINSTATEMENT 32

Cancellation Without Cause....32
Cancellation for Non-Payment of Dues - Notices....32
Cancellation/Rescission for Fraud or Intentional, Misrepresentations of Material Fact....33
Plan Changes....33
Right of Cancellation....33
XI. MEMBER SERVICES AND GRIEVANCE PROCESS....33
Member Services....33
Grievance Process....33
XII. OTHER PROVISIONS....34
Department of Managed Health Care Review....34
Public Policy Participation Procedure....34
Grace Period....35
Right of Recovery....35
Confidentiality of Personal and Health Information....35
Access to Information....35
Non-Assignability....35
Participating Dentist Network....35
Independent Contractors....36
XIII. DEFINITIONS....36

blue of california

Group Dental Plan
DHMO Plan

Summary of Benefits

Dental HMO Deluxe

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Dental Provider Network: DHMO Network

This Plan uses a specific network of dental care providers, called the DHMO provider network. Dentists in this network are called Participating Dentists. You must select a Participating Dentist from this network to provide your primary dental care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Dentist[3]
Calendar Year Deductible	*Individual coverage*	$0
	Family coverage	$0

Calendar Year Benefit Maximum

This Plan pays up to the maximum payment amount as listed for Covered Services and supplies per year.

	When using a Participating Dentist[3]
Calendar Year Benefit Maximum	No maximum

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services.

Waiting period	No waiting period

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
	Diagnostic services (exams and x-rays)	
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation – problem focused	$0
D0145	Oral evaluation for a patient under three years of age	$0
D0150	Comprehensive oral evaluation	$0
D0160	Detailed and extensive oral evaluation – problem focused	$0
D0170	Re-evaluation – limited, problem focused (not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
D0210	Intraoral complete series radiographs - includes bitewings (once every 36 months)	$0
D0220	Intraoral periapical radiograph – first film	$0
D0230	Intraoral periapical radiograph – each additional film	$0
D0240	Intraoral occlusal radiograph	$0
D0270	Bitewing radiograph – single film	$0
D0272	Bitewing radiograph – two films	$0
D0273	Bitewing radiograph – three films	$0
D0274	Bitewing radiograph – four films	$0
D0330	Panoramic radiograph film (once every 36 months)	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities, including premalignant and malignant lesions (not to include cytology or biopsy procedures)	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
	Preventive services (cleanings and fluoride)	
D1110	Prophylaxis – adult age17 and older (once every 6 months)	$0
D1110	Prophylaxis – adult age17 and older (additional within the 6-month period)	$45
D1120	Prophylaxis – child through age 16 (once every 6 months)	$0
D1120	Prophylaxis – child through age 16 (additional within the 6-month period)	$35
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride – excluding varnish	$0
D1330	Oral hygiene instructions	$0

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D1351	Sealant – per tooth	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth – child through age 18	$0
D1510	Space maintainer – fixed - unilateral – per quadrant	$5
D1516	Space maintainer – fixed – bilateral, maxillary	$5
D1517	Space maintainer – fixed – bilateral, mandibular	$5
D1520	Space maintainer – removable - unilateral – per quadrant	$5
D1526	Space maintainer – removable – bilateral, maxillary	$5
D1527	Space maintainer – removable – bilateral, mandibular	$5
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$5
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$5
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$5
D1556	Removal of fixed unilateral space maintainer – per quadrant	$0
D1557	Removal of fixed bilateral space maintainer – maxillary	$0
D1558	Removal of fixed bilateral space maintainer – mandibular	$0
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant	$5
	Minor Restorative services (fillings)	
D2140	Amalgam – one surface, primary or permanent	$0
D2150	Amalgam – two surfaces, primary or permanent	$0
D2160	Amalgam – three surfaces, primary or permanent	$0
D2161	Amalgam – four or more surfaces, primary or permanent	$0
D2330	Resin-based composite – one surface, anterior	$0
D2331	Resin-based composite – two surfaces, anterior	$0
D2332	Resin-based composite – three surfaces, anterior	$0
D2335	Resin-based composite – four or more surfaces or involving incisal angle, anterior	$0
D2390	Resin-based composite – crown, anterior	$150
D2391	Resin-based composite – one surface, posterior	$61/tooth
D2392	Resin-based composite – two surfaces, posterior	$72
D2393	Resin-based composite – three surfaces, posterior	$93
D2394	Resin-based composite – four or more surfaces, posterior	$114
	Major Restorative services (crowns)	
D2510	Inlay – metallic – one surface	$125
D2520	Inlay – metallic – two surfaces	$125
D2530	Inlay – metallic – three or more surfaces	$125
D2542	Onlay – metallic – two surfaces	$125
D2543	Onlay – metallic – three surfaces	$125
D2544	Onlay – metallic – four or more surfaces	$125

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D2610	Inlay – porcelain/ceramic – one surface	$250
D2620	Inlay – porcelain/ceramic – two surfaces	$260
D2630	Inlay – porcelain/ceramic – three or more surfaces	$275
D2642	Onlay – porcelain/ceramic – two surfaces	$250
D2643	Onlay – porcelain/ceramic – three surfaces	$260
D2644	Onlay – porcelain/ceramic – four or more surfaces	$275
D2650	Inlay – resin-based composite – one surface	$215
D2651	Inlay – resin-based composite – two surfaces	$225
D2652	Inlay – resin-based composite – three or more surfaces	$245
D2662	Onlay – resin-based composite – two surfaces	$215
D2663	Onlay – resin-based composite – three surfaces	$225
D2664	Onlay – resin-based composite – four or more surfaces	$245
D2710	Crown – resin-based composite – indirect	$165/crown
D2720	Crown – resin with high noble metal	$260/crown[6]
D2721	Crown – resin with predominantly base metal	$195/crown[6]
D2722	Crown – resin with noble metal	$225/crown[6]
D2740	Crown – porcelain/ceramic	$125/crown[6]
D2750	Crown – porcelain fused to high noble metal	$125/crown[6]
D2751	Crown – porcelain fused to predominantly base metal	$125/crown[6]
D2752	Crown – porcelain fused to noble metal	$125/crown[6]
D2753	Crown – porcelain fused to titanium and titanium alloys	$125/crown[6]
D2780	Crown – 3/4 cast high noble metal	$125/crown[6]
D2781	Crown – 3/4 cast predominantly base metal	$125/crown[6]
D2782	Crown – 3/4 cast noble metal	$125/crown[6]
D2783	Crown – 3/4 porcelain/ceramic	$125/crown[6]
D2790	Crown – full cast high noble metal	$125/crown[6]
D2791	Crown – full cast predominantly base metal	$125/crown[6]
D2792	Crown – full cast noble metal	$125/crown[6]
D2794	Crown – titanium and titanium alloys	$125/crown[6]
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$9
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10
D2920	Re-cement or re-bond crown	$5
D2930	Prefabricated stainless steel crown – primary tooth	$5
D2931	Prefabricated stainless steel crown – permanent tooth	$15
D2932	Prefabricated resin crown	$25
D2933	Prefabricated stainless steel crown with resin window	$20
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	$20
D2940	Protective restoration	$10

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D2950	Core buildup, including any pins when required	$24
D2951	Pin retention – per tooth, in addition to restoration	$5/tooth
D2952	Post and core in addition to crown – indirectly fabricated	$36
D2953	Each additional indirectly fabricated post – same tooth	$25
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal	$0
D2957	Each additional prefabricated post – same tooth	$16
D2980	Crown repair necessitated by restorative material failure	$25
D2981	Inlay repair necessitated by restorative material failure	$10
D2982	Onlay repair necessitated by restorative material failure	$15
	Endodontic services (root canals)	
D3110	Pulp cap – direct (excluding final restoration)	$0
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$5
D3221	Pulpal debridement – primary and permanent tooth	$10
D3310	Endodontic therapy – anterior tooth (excluding final restoration)	$50
D3320	Endodontic therapy – premolar tooth (excluding final restoration)	$80
D3330	Endodontic therapy – molar tooth (excluding final restoration)	$145
D3331	Treatment of root canal obstruction – non-surgical access	$25
D3332	Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth	$40
D3346	Retreatment of previous root canal therapy – anterior	$50
D3347	Retreatment of previous root canal therapy – bicuspid	$70
D3348	Retreatment of previous root canal therapy – molar	$90
D3410	Apicoectomy – anterior	$20/first root
D3421	Apicoectomy – premolar – first root	$20
D3425	Apicoectomy – molar – first root	$20
D3426	Apicoectomy – each additional root	$20
D3430	Retrograde filling – per root	$23
D3450	Root amputation – per root	$100
D3920	Hemisection, including any root removal (not including root canal therapy)	$25
D3950	Canal preparation and fitting of preformed dowel or post	$0
	Periodontic services (gum disease)	
D4210	Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces – per quadrant	$75
D4211	Gingivectomy/gingivoplasty – one to three contiguous teeth or tooth bounded spaces – per quadrant	$15

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D4212	Gingivectomy/gingivoplasty – to allow access for restorative procedure – per tooth	$0
D4240	Gingival flap procedure, including root planing – four or more teeth – per quadrant	$125
D4241	Gingival flap procedure, including root planing – one to three teeth – per quadrant	$63
D4260	Osseous surgery, including elevation of a full thickness flap and closure – four or more contiguous teeth or tooth bounded spaces – per quadrant	$125
D4261	Osseous surgery, including elevation of full thickness flap and closure – one to three contiguous teeth or tooth bounded spaces – per quadrant	$63
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$58
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$43
D4266	Guided tissue regeneration – resorbable barrier – per site	$72
D4267	Guided tissue regeneration – non-resorbable barrier – per site, includes membrane removal	$83
D4270	Pedicle soft tissue graft procedure	$70
D4273	Autogenous connective tissue graft procedure, including donor and recipient surgical sites – first tooth – implant or edentulous tooth position in graft	$90
D4277	Free soft tissue graft procedure, including recipient and donor surgical sites –first tooth, implant, or edentulous tooth position in graft	$75
D4278	Free soft tissue graft procedure, including recipient and donor surgical sites – each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$45
D4341	Periodontal scaling and root planing – four or more teeth – per quadrant	$10
D4342	Periodontal scaling and root planing – one to three teeth – per quadrant	$5
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (11 years of age and older; once per 12 months)	$5
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$10
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue – per tooth	$6
D4910	Periodontal maintenance	$5
	Removable prosthetic services (dentures)	
D5110	Complete denture – maxillary	$100/denture
D5120	Complete denture – mandibular	$100/denture
D5130	Immediate denture – maxillary	$100/denture
D5140	Immediate denture – mandibular	$100/denture
D5211	Maxillary partial denture – resin base, including retentive/clasping materials, rests and teeth	$175/denture
D5212	Mandibular partial denture – resin base, including retentive/clasping materials, rests and teeth	$175/denture
D5213	Maxillary partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests and teeth	$175/denture[6]
D5214	Mandibular partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests and teeth	$175/denture[6]

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D5225	Maxillary partial denture – flexible base, including any clasps, rests and teeth	$175/denture
D5226	Mandibular partial denture – flexible base, including any clasps, rests and teeth	$175/denture
D5282	Removable unilateral partial denture – one-piece cast metal, including clasps and teeth, maxillary	$175/denture[6]
D5283	Removable unilateral partial denture – one-piece cast metal, including clasps and teeth, mandibular	$175/denture[6]
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	$175/denture
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	$175/denture
D5410	Adjust complete denture – maxillary	$25
D5411	Adjust complete denture – mandibular	$25
D5421	Adjust partial denture – maxillary	$25
D5422	Adjust partial denture – mandibular	$25
D5511	Repair broken complete denture base – mandibular	$25[7]
D5512	Repair broken complete denture base – maxillary	$25[7]
D5520	Replace missing or broken teeth – complete denture – each tooth	$25[7]
D5611	Repair resin partial denture base – mandibular	$25[7]
D5612	Repair resin partial denture base – maxillary	$25[7]
D5621	Repair cast partial framework – mandibular	$25[7]
D5622	Repair cast partial framework – maxillary	$25[7]
D5630	Repair or replace broken retentive/clasping materials – per tooth	$25[7]
D5640	Replace broken teeth – per tooth	$25[7]
D5650	Add tooth to existing partial denture	$25[7]
D5660	Add clasp to existing partial denture – per tooth	$25[7]
D5670	Replace all teeth and acrylic on cast metal framework – maxillary	$105[7]
D5671	Replace all teeth and acrylic on cast metal framework – mandibular	$105[7]
D5710	Rebase – complete maxillary denture	$25
D5711	Rebase – complete mandibular denture	$25
D5720	Rebase – partial maxillary denture	$25
D5721	Rebase – partial mandibular denture	$25
D5730	Reline complete maxillary denture – chairside	$25/denture[7]
D5731	Reline complete mandibular denture – chairside	$25/denture[7]
D5740	Reline maxillary partial denture – chairside	$25/denture[7]
D5741	Reline mandibular partial denture – chairside	$25/denture[7]
D5750	Reline complete maxillary denture – laboratory	$50/denture[7]
D5751	Reline complete mandibular denture – laboratory	$50/denture[7]
D5760	Reline maxillary partial denture – laboratory	$50/denture[7]
D5761	Reline mandibular partial denture – laboratory	$50/denture[7]

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D5850	Tissue conditioning – maxillary	$5/denture unit
D5851	Tissue conditioning – mandibular	$5/denture unit
	Implant services	
D6010	Surgical placement of implant body – endosteal implant	$1,375
D6056	Prefabricated abutment – includes modifications and placement	$500
D6057	Custom fabricated abutment – includes placement	$600
D6058	Abutment supported porcelain/ceramic crown	$1,250
D6059	Abutment supported porcelain fused to metal crown – high noble metal	$1,250
D6060	Abutment supported porcelain fused to metal crown – predominately base metal	$1,150
D6061	Abutment supported porcelain fused to metal crown – noble metal	$900
D6062	Abutment supported cast metal crown – high noble metal	$1,000
D6063	Abutment supported cast metal crown – predominately base metal	$962
D6064	Abutment supported cast metal crown – noble metal	$825
D6065	Implant supported porcelain/ceramic crown	$1,250
D6066	Implant supported crown - porcelain fused to high noble alloys	$1,250
D6067	Implant supported crown – high noble alloys	$1,300
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$225
D6082	Implant supported crown – porcelain fused to predominantly base alloys	$1,150
D6083	Implant supported crown – porcelain fused to noble alloys	$900
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	$1,150
D6086	Implant supported crown – predominantly base alloys	$962
D6087	Implant supported crown – noble alloys	$825
D6088	Implant supported crown – titanium and titanium alloys	$962
D6090	Repair implant supported prosthesis, by report	$288
D6092	Re-cement or re-bond implant/abutment supported crown	$109
D6094	Abutment supported crown – titanium and titanium alloys	$913
D6095	Repair implant abutment, by report	$300
D6096	Remove broken implant retaining screw	$0
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	$1,150
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	$1,150
D6100	Implant removal, by report	$500
	Bridges, abutments or pontic services	
D6205	Pontic – indirect resin-based composite	$125/tooth replaced[6]
D6210	Pontic – cast high noble metal	$125[6]
D6211	Pontic – cast predominantly base metal	$125[6]
D6212	Pontic – cast noble metal	$125[6]

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D6214	Pontic – titanium and titanium alloys	$125
D6240	Pontic – porcelain fused to high noble metal	$125[6]
D6241	Pontic – porcelain fused to predominantly base metal	$125[6]
D6242	Pontic – porcelain fused to noble metal	$125[6]
D6243	Pontic – porcelain fused to titanium and titanium alloys	$125[6]
D6245	Pontic – porcelain/ceramic	$125[6]
D6250	Pontic – resin with high noble metal	$125[6]
D6251	Pontic – resin with predominantly base metal	$125[6]
D6252	Pontic – resin with noble metal	$125[6]
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$125[6]
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$125[6]
D6600	Retainer inlay – porcelain/ceramic – two surfaces	$125[6]
D6601	Retainer inlay – porcelain/ceramic – three or more surfaces	$125[6]
D6602	Retainer inlay – cast high noble metal – two surfaces	$125[6]
D6603	Retainer inlay – cast high noble metal – three or more surfaces	$125[6]
D6604	Retainer inlay – cast predominantly base metal – two surfaces	$125[6]
D6605	Retainer inlay – cast predominantly base metal – three or more surfaces	$125[6]
D6606	Retainer inlay – cast noble metal – two surfaces	$125[6]
D6607	Retainer inlay – cast noble metal – three or more surfaces	$125[6]
D6608	Retainer onlay – porcelain/ceramic – two surfaces	$125[6]
D6609	Retainer onlay – porcelain/ceramic – three or more surfaces	$125[6]
D6610	Retainer onlay – cast high noble metal – two surfaces	$125[6]
D6611	Retainer onlay – cast high noble metal – three or more surfaces	$125[6]
D6612	Retainer onlay – cast predominantly base metal – two surfaces	$125[6]
D6613	Retainer onlay – cast predominantly base metal – three or more surfaces	$125[6]
D6614	Retainer onlay – cast noble metal – two surfaces	$125[6]
D6615	Retainer onlay – cast noble metal – three or more surfaces	$125[6]
D6710	Retainer crown – indirect resin-based composite	$125[6]
D6720	Retainer crown – resin with high noble metal	$125[6]
D6721	Retainer crown – resin with predominantly base metal	$125[6]
D6722	Retainer crown – resin with noble metal	$125[6]
D6740	Retainer crown – porcelain/ceramic	$125[6]
D6750	Retainer crown – porcelain fused to high noble metal	$125[6]
D6751	Retainer crown – porcelain fused to predominantly base metal	$125[6]
D6752	Retainer crown – porcelain fused to noble metal (anterior and premolar teeth only)	$125[6]
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$125[6]
D6780	Retainer crown – 3/4 cast high noble metal	$125[6]
D6781	Retainer crown – 3/4 cast predominantly base metal	$125[6]

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D6782	Retainer crown – 3/4 cast noble metal	$125[6]
D6783	Retainer crown – 3/4 porcelain/ceramic (anterior and premolar teeth only)	$125[6]
D6784	Retainer crown – 3/4 titanium and titanium alloys	$125[6]
D6790	Retainer crown – full cast high noble metal	$125[6]
D6791	Retainer crown – full cast predominantly base metal	$125[6]
D6792	Retainer crown – full cast noble metal	$125[6]
D6794	Retainer crown – titanium and titanium alloys	$125
D6930	Re-cement or re-bond fixed partial denture	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$5[7]
	Oral surgery services	
D7111	Extraction – coronal remnants – primary tooth	$3/tooth
D7140	Extraction – erupted tooth or exposed root, including elevation and/or forceps removal	$6/tooth
D7210	Extraction – erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	$15/tooth
D7220	Removal of impacted tooth – soft tissue	$20/tooth
D7230	Removal of impacted tooth – partially bony	$40/tooth
D7240	Removal of impacted tooth – completely bony	$65/tooth
D7241	Removal of impacted tooth – completely bony with unusual surgical complications	$65/tooth
D7250	Removal of residual tooth roots – cutting procedure	$30
D7251	Coronectomy – intentional partial tooth removal	$38
D7260	Oroantral fistula closure	$70
D7285	Incisional biopsy of oral tissue – hard – bone or tooth	$13[8]
D7286	Incisional biopsy of oral tissue – soft	$10[8]
D7287	Exfoliative cytological sample collection	$10
D7288	Brush biopsy – transepithelial sample collection	$5
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	$38
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$10
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	$30
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$15
D7471	Removal of lateral exostosis – maxilla or mandible	$53
D7472	Removal of torus palatinus	$63
D7473	Removal of torus mandibularis	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$20

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated, includes drainage of multiple facial spaces	$28
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$44
D7960	Frenulectomy/frenectomy/frenotomy – separate procedure not incidental to another procedure	$38
D7963	Frenuloplasty	$41
D7970	Excision of hyperplastic tissue – per arch	$43
D7971	Excision of pericoronal gingiva	$20
D7972	Surgical reduction of fibrous tuberosity	$60
	Orthodontic services	
D8070	Comprehensive Orthodontic treatment of the transitional dentition – (child through age 13)	$1,200[9]
D8080	Comprehensive Orthodontic treatment of the adolescent dentition	$1,200[9]
D8090	Comprehensive Orthodontic treatment of the adult dentition	$1,500[9]
D8210	Removable appliance therapy	$360[9]
D8220	Fixed appliance therapy	$406[9]
D8660	Pre-Orthodontic treatment examination to monitor growth and development	$250[9]
D8670	Periodic Orthodontic treatment visit	$0/visit[9]
D8680	Orthodontic retention, including removal of appliances, construction and placement of retainer(s)	$250/retainer[9]
D8696	Repair of Orthodontic appliance - maxillary	$88[9]
D8697	Repair of Orthodontic appliance - mandibular	$88[9]
	Adjunctive general services	
D9110	Palliative emergency treatment of dental pain – minor procedure	$20/visit[10]
D9120	Fixed partial denture sectioning	$37
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9220	General anesthesia - first 30 minutes	$0
D9221	General anesthesia - each additional 15 minutes	$0
D9222	Deep sedation/general anesthesia – first 15 minutes	$0
D9239	Intravenous moderate conscious sedation/anesthesia – first 15 minutes	$0
D9241	IV sedation - first 30 minutes	$0
D9242	IV sedation - each additional 15 minutes	$0
D9310	Consultation – diagnostic consultation provided by dentist or physician other than requesting dentist or physician (as necessary)	$0

Benefits[4,5]	Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating Dentist[3]
D9430	Office visit for observation during regularly scheduled hours – no other services performed	$6/visit
D9440	Office visit – after regularly scheduled hours	$40/visit
D9910	Application of desensitizing medicament	$10
D9941	Fabrication of athletic mouthguard (for ages 12 and older)	$34
D9942	Repair and/or reline of occlusal guard	$40
D9944	Occlusal guards – hard appliance, full arch	$80
D9945	Occlusal guards – soft appliance, full arch	$80
D9946	Occlusal guards – hard appliance, partial arch	$80
D9951	Occlusal adjustment – limited	$25/entire mouth
D9952	Occlusal adjustment – complete	$25/entire mouth
	Other services	
D9999	Failed Appointment without 24-hour notice – per 15 minutes of appointment time	$20/visit

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

3 Using Participating Dentists:

Participating Dentists have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Participating Dentist, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

4 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance.

5 Dental Care Services:

All dental Benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Notes

Dental Care Covered Services. All Covered Services must be Medically Necessary and must be provided by the Member's Dental Center or other Participating Dentist when referred by the Member's Dental Center and Authorized by the contracted Dental Plan Administrator.

6 Metals and Porcelain:

Precious (high noble) and semi-precious (noble) metals are subject to an additional charge. If these metals are used for fillings, crowns, bridges, or prosthetic devices, they are subject to an additional charge of $150 per unit.

Porcelain on molar crowns is subject to an additional cost of $200 per unit.

7 Denture Reline Services:

The Copayment or Coinsurance for Covered Services applies if done within six (6) months of the initial insertion of a denture. Denture relines after six (6) months of the initial insertion of a denture require the additional denture reline Copayment or Coinsurance.

8 Laboratory Services:

Denture repair, biopsy, and excision Covered Services are subject to an additional charge for lab fees. The Member is responsible for paying the lab fees plus any applicable Copayment or Coinsurance for these services.

9 Orthodontic Services:

Orthodontic Covered Services. The Copayment or Coinsurance for Medically Necessary Orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

Full case fee. The full case fee for Orthodontic Covered Services includes a consultation, a treatment plan, tooth movement, and retention limited to $250 per case. Orthodontists may charge Members separately for records.

0 Palliative Emergency Treatment:

For an emergency oral exam with palliative treatment, if the treatment includes a listed procedure, then the regular Copayment or Coinsurance applies.

Plans may be modified to ensure compliance with State and Federal requirements.

I. Introduction to the Blue Shield Dental HMO Plan

Your interest in the Blue Shield Dental HMO Plan is truly appreciated. Blue Shield has been serving Californians for over 60 years, and we look forward to serving your dental care needs.

By choosing a Blue Shield Dental HMO Plan (Plan) you've selected a Plan that has significant differences from not only the other dental care coverages provided by Blue Shield but also from the dental care coverage provided by most other dental plans.

The Blue Shield Dental HMO Plan offers you a dental Plan with a wide choice of Plan Dental Providers. Not only will you be able to select your own dental office from the Dental HMO Dental Provider Directory, but each of your eligible Family Members may also select their own Dental Provider. All Covered Services will be provided by or arranged through your Dental Center.

You will have the opportunity to be an active participant in your own dental care. The Blue Shield Dental HMO Plan will help you make a personal commitment to maintaining and, where possible, improving your dental health status. Like you, we believe that maintaining a healthy lifestyle and preventing dental illness are as important as caring for your needs when dental problems arise.

Please review this booklet which summarizes the coverage and general provisions of the Blue Shield Dental HMO Plan.

Blue Shield of California's dental Plans are administered by a Dental Plan Administrator (DPA).

If you have any questions regarding the information in this booklet, need assistance, or have any problems, you may contact Blue Shield or your dental Member Services Department:

General and Eligibility Inquiry:

In California 1-800-585-8111

Outside California 1-800-323-7201

Problem Resolution and/or Grievances:

In California 1-800-585-8111

Outside California 1-800-323-7201

II. Evidence of Coverage Statement

This Evidence of Coverage booklet constitutes only a summary of the Plan. The Dental Services Contract must be consulted to determine the exact terms and conditions of coverage.

The Dental Services Contract is available through your Employer or a copy can be furnished upon request. Your Employer is familiar with this Plan, and you may also direct questions concerning Covered Services or specific Plan provisions to the Blue Shield Plan Member Services Department.

III. Choice of Dental Provider

Selecting A Dental Provider

A close Dentist-patient relationship is an important element that helps to ensure the best dental care. Each Member (Subscriber or Dependent) is therefore required to select a Dental Provider at the time of enrollment. This decision is an important one because your Dental Provider will:

1. Help you decide on actions to maintain and improve your dental health.
2. Provide, coordinate and direct all necessary covered Dental Care Services.
3. Arrange referrals to Plan Specialists when required, including the prior Authorization you will need.
4. Authorize Emergency Services when necessary.

The Dental Provider for each Member must be located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by the Plan.

A Dental Provider must also be selected for a newborn or child placed for adoption.

If you do not select a Dental Provider at the time of enrollment or seek assistance from the Dental Plan Member Services Department within 15 days of the effective date of coverage, the Plan will designate a temporary Dental Provider for you and your Dependents, and notify you of the designated Dental Provider. This designation will remain in effect until you advise the Plan of your selection of a different Dental Provider.

Changing Dental Providers

You or a Dependent may change Dental Providers without cause at the following times:

1. during your Employer's annual open enrollment;
2. when your change in residence or work address makes it inconvenient to continue with the same Dental Provider;

3. one other time during the Calendar Year.

If you want to change Dental Providers at any of the above times, you must contact Dental Member Services. Before changing Dental Providers you must pay any outstanding Copayment balance owed to your existing Dental Provider. The change will be effective the first day of the month following notice of approval by the Plan.

If your Dental Provider ceases to be in the Participating Dentist network, the Plan will notify you in writing. To ensure continuity of care you will temporarily be assigned to an alternate Dental Provider and asked to select a new Dental Provider. If you do not select a new Dental Provider within the specified time, your alternate Dental Provider assignment will remain in effect until you notify the Plan of your desire to select a new Dental Provider.

Continuity of Care by a Terminated Provider

Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving a Dental Plan Administrator's Participating Dentist network. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Continuity of Care for New Members by Non-Contracting Providers

Newly covered Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age; or who have received authorization from a provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracting provider who was providing services to the Member at the time the Member's coverage became effective under this Plan. Contact Member Services to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

Payment of Providers

Blue Shield contracts with a Dental Plan Administrator to provide services to our Members. A monthly fee is paid to a Dental Plan Administrator for each Member. This payment system includes incentives to a Dental Plan Administrator to manage all Covered Services provided to Members in an appropriate manner consistent with the Contract.

Your Dental Provider must obtain Authorization from a Dental Plan Administrator before referring you to providers outside of the Dental Center.

If you want to know more about this payment system, contact a Dental Plan Administrator at the number shown in the Member Services section of this booklet or talk to your Participating Dentist.

Relationship with your Dental Provider

The Dentist-patient relationship you establish with your Dental Provider is very important. The best effort of your Dental Provider will be used to ensure that all Medically Necessary and appropriate professional services are provided to you in a manner compatible with your wishes.

If your Dentist recommends procedures or treatment which you refuse, or you and the Dental Provider fail to establish a satisfactory relationship, you may select a different Dental Provider. The Plan Member Services can assist you with this selection.

Your Dental Provider will advise you if they believe there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the recommended treatment or procedure, the Plan Member Services can assist you in the selection of another Dental Provider.

IV. How To Use Your Dental Plan

Use of Dental Provider

At the time of enrollment, you will choose a Dental Provider that will provide and coordinate all covered dental services. You must contact your Dental Provider for all dental care needs including preventive services, routine dental problems, consultation with Plan Specialists and Emergency Services. The Dental Provider is responsible for providing general Dental Care Services and coordinating or arranging for referral to other necessary Plan Specialists. The Plan must authorize such referrals.

To avoid a failed appointment charge, you must always cancel any scheduled appointments at least 24 hours in advance.

If the Member needs help finding a Participating Dentist who can provide care close to home, the Member should call Member Services. If a Participating Dentist is not available, the Member can ask to see a Non-Participating Dentist at

the Participating Dentist Cost Share. If the services cannot reasonably be obtained from a Participating Dentist, the Plan will approve the request and the Member will only be responsible for the Participating Dentist Cost Share.

To obtain Benefits under your Plan, you must attend the Dental Provider you selected. If for any reason you did not select a Dental Provider, contact Member Services at:

In California 1-800-585-8111

Outside California 1-800-323-7201

Referral to Plan Specialists

All specialty Dental Care Services must be provided by or arranged for by the Dental Provider. Referral by a Dental Provider does not guarantee coverage for the services for which the Member is being referred. The Benefit and eligibility provisions, exclusions, and limitations will apply. Members may be referred to a Plan Specialist within the Dental Center. However, you may also be referred to a Plan Specialist outside of the Dental Center if the type of specialty service needed is not available within your Dental Center.

If the Dental Provider determines specialty Dental Care Services are necessary, they will complete a referral form and you will then be able to schedule an appointment with a Plan Specialist. When no Participating Dentist is available to perform the needed service, the Dental Provider will refer you to a Non-Participating Dentist after obtaining Authorization from a Dental Plan Administrator. This Authorization procedure is handled for you by your Dental Provider.

Generally, your Dental Provider will refer you within the network of Blue Shield Plan Specialists in your area. After the specialty services have been rendered, the Plan Specialist will provide a complete report to your Dental Provider to ensure your dental record is complete.

Emergency Services

An emergency means, "an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) subjecting the Member to undue suffering."

For Emergency Services within your Service Area you should first notify your Dental Provider to obtain care, Authorization, or instructions for care prior to actual emergency treatment. If it is not possible to notify your Dental Provider prior to receiving Emergency Services, you must notify your Dental Provider within 24 hours after care is received unless it was not reasonably possible to communicate within this time limit. In such case, notice must be given as soon as possible. Failure to provide notice as stated may result in the services not being covered.

If you are in need of emergency treatment and are outside the geographic area of your designated Dental Provider, you should first contact a Dental Plan Administrator to describe the emergency and receive referral instructions. If a Dental Plan Administrator does not have a Dentist in the area, or if you are unable to contact a Dental Plan Administrator, you should contact a Dentist of your choice. You will be directly reimbursed for this treatment up to the maximum allowed under your Plan Benefits. Refer to the section titled "Responsibility for Copayments, Charges for non-Covered Services and Emergency Claims" within the insert.

NOTE: A Dental Plan Administrator will respond to all requests for prior Authorization of services as follows:

for urgent services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;

for other services, within 5 business days from receipt of the request.

If you obtain services without prior Authorization from a Dental Plan Administrator, a Dental Plan Administrator will retrospectively review the services for coverage as Emergency Services. If a Dental Plan Administrator determines that the situation did not require Emergency Services, you will be responsible for the entire cost of the services. A Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

Out-of-Area Benefits

If a Member receives Emergency Services outside the Service Area, the Member shall be entitled to reimbursement of up to fifty dollars ($50) per occurrence for such Covered Services. Whenever possible, the Member should ask the provider to bill the Plan directly.

Payment or reimbursement of Emergency Services provided to a Member will be made after a Dental Plan Administrator receives documentation of the charges incurred and upon approval by a Dental Plan Administrator of those charges set forth. Except for Emergency Services, as noted above, a Member will be responsible for full payment of dental services rendered outside the Service Area.

In-Area Benefits (Those received within the Service Area)

Palliative Treatment received in an emergency from a Non-Participating Dentist will be covered according to the Summary of Benefits, if the Member has attempted but failed to reach his or her designated Dental Provider during the emergency.

If the Member receives Emergency Services from a Non-Participating Dentist, a Dental Plan Administrator will retrospectively review the services provided. If a Dental Plan Administrator determines that the situation did not require Emergency Services, the Member will be responsible for the entire cost of the services. A Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

Limitation of Member Liability

When a Participating Dentist renders Covered Services, the Member is responsible only for the applicable Copayments and charges in excess of Benefit maximums. Members are responsible for the full charges for any non-Covered Services they obtain.

If a Dental Provider ceases to be in the Participating Dentist network, you will be notified if you are affected. The provider is required to complete any work in progress, after which you must select a new provider. Once provisions have been made for the transfer of your care, services of a former Participating Dentist are no longer covered, except as provided for in the sections entitled "Choice of Dental Provider" and "Continuity of Care by a Terminated Provider".

You will not be responsible for payment (other than Copayments) to a former Participating Dentist for any Covered Services you receive prior to the effective date of the transfer to a new Dental Provider.

Responsibility for Copayments, Charges for Non-Covered Services, AND Emergency Claims

Member Responsibility

The Member shall be responsible to the Dental Provider and other Participating Dentists for payment of the following charges:

1. Any amounts listed under Copayments in the preceding Summary of Benefits.
2. Any charges for non-Covered Services.

All such Copayments and charges for non-Covered Services are due and payable to the Dental Provider or Participating Dentists immediately upon commencement of extended treatments or upon the provision of services. Termination of the Plan shall in no way affect or limit any liability or obligation of the Member to the Dental Provider or other Participating Dentist for any such Copayments or charges owing.

Elective Treatment for Non-Covered Services

When the Member and Participating Dentist opt to select a procedure that is more expensive than the Covered Benefit, the Member will be responsible for the Copayment of the Covered Services and the difference between the Dentist's billed charges for selected procedure. If no dental service appearing on the Summary of Benefits is related to the procedure selected, the service is excluded as listed in the section entitled "General Exclusions". In all instances, Benefits will be provided for Medically Necessary restoration of tooth structure.

Emergency Claims

If Emergency Services outside of the Service Area were received and expenses were incurred by the Member, the Member must submit a complete claim with the Emergency Service record (a copy of the Dentist's bill) for payment to a Dental Plan Administrator, within 1 year after the treatment date.

Please send this information to:
Blue Shield of California
P.O. Box 30567
Salt Lake City, UT 84130-0567

If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not pre-authorized, a Dental Plan Administrator will review the claim retrospectively. If a Dental Plan Administrator determines that the services were not Emergency Services and would not otherwise have been authorized by a Dental Plan Administrator, and, therefore, are not Covered Services under the dental Plan Contract, it will notify the Member of that determination. The Member is responsible for the payment of such Dental Care Services received. A Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim. If the Member disagrees with a Dental Plan Administrator's decision, he may appeal using the procedures outlined in the section entitled "Member services and Grievance Process".

Blue Shield Online

Blue Shield's internet site is located at http://www.blueshieldca.com. Members using a personal computer and modem with World Wide Web access may view and download healthcare information and software.

V. PLAN BENEFITS

The Benefits available to you under the Plan are listed in the Summary of Benefits. The Copayments for these services, if applicable, are also listed in the Summary of Benefits.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

Important Information

The Dental Care Services (Benefits) described in this booklet and its accompanying insert are covered only if they are Medically Necessary and are provided, prescribed, or referred by your Dental Provider and are approved by a Dental Plan Administrator. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Contract, and to the General Exclusions and Limitations set forth in the section entitled "General Exclusions and Limitations". A Dental Plan Administrator will not pay charges incurred for services without your Dental Provider's and/or a Dental Plan Administrator's prior Authorization except for Emergency Services obtained in accordance with the section entitled "How To Use Your Dental Plan".

The determination of whether services are Medically Necessary or are an emergency will be made by a Dental Plan Administrator. This determination will be based upon the Plan's review consistent with generally accepted dental standards, and will be subject to appeal in accordance with the procedures outlined in the section entitled "Member Services and Grievance Process".

Member Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments by the Plan for Covered Services provided under the Plan.

VI. GENERAL EXCLUSIONS AND LIMITATIONS

General Exclusions

Unless otherwise specifically mentioned elsewhere in the Contract this Plan does not provide Benefits with respect to:

1. dental services not appearing on the Summary of Benefits;
2. services of Dentists or other practitioners of healing arts not associated with the dental Plan, except upon referral arranged by a Dental Provider and authorized by the Plan or when required in a covered emergency;
3. dental treatment that has been previously started by another Dentist prior to the participant's eligibility to receive Benefits under this Plan;
4. dental services performed in a hospital or any related hospital fee;
5. any procedure not performed in a dental office setting; except for general anesthesia when Medically Necessary;
6. procedures that are principally cosmetic in nature, including, but not limited to, bleaching, veneer facings, crowns, porcelain on molar crowns, personalization or characterization of crowns, bridges and/or dentures;
7. services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;
8. all prescription and non-prescription drugs;
9. congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery, including Orthodontic treatment, and oral and maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging;
10. any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by the Dental Plan Administrator and its dental consultants;
11. reimbursement to the Member or another dental office for the cost of services secured from Dentists, other than the Dental Center or other Plan Authorized Provider, except:
    a. when such reimbursement is expressly authorized by the Plan; or
    b. as cited under the Emergency Services and Emergency Claims provisions.

12. charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
13. treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;
14. treatment for which payment is made by any governmental agency, including any foreign government;
15. diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint;
16. bone grafting done for socket preservation after tooth extraction or in preparation for Implants;
17. general anesthesia; including intravenous and inhalation sedation, except when of Medical Necessity;

    General anesthesia is considered medically necessary when its use is:

    (a) in accordance with generally accepted professional standards;

    (b) not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; and

    (c). due to the existence of a specific medical condition.

    Written documentation of the medical condition necessitating use of general anesthesia or intravenous or sedation must be provided by a physician (M.D.) to the Dental Provider and approved by a Dental Plan Administrator.

    Patient apprehension or patient anxiety will not constitute Medical Necessity.

    Mental disability is an acceptable medical condition to justify use of general anesthesia.

    The Plan reserves the right to review the use of general anesthesia to determine Medical Necessity;
18. precious metals (if used, will be charged to the patient at the Dentist's cost);
19. removal of 3rd molar (wisdom teeth) other than for Medical Necessity. Medical Necessity pertaining to the removal of 3rd molar (wisdom teeth) is defined as a pathological condition which includes horizontal, mesial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not Medical Necessity;
20. services of Prosthodontists;
21. referral of a Dependent child age six (6) and over to a Pedodontist, unless the child is mentally disabled and will not allow the general Dentist to treat after two attempts. All such exceptions must be approved by a Dental Plan Administrator;
22. treatment as a result of Accidental Injury, including setting of fractures or dislocation;
23. charges for second opinions, unless previously authorized by the Dental Plan Administrator;
24. services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;
25. services provided to Members by out-of-network Dentists unless preauthorized by the Plan, except when immediate dental treatment is required as a result of a dental emergency;
26. services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;
27. replacement of lost, missing, stolen or damaged or prosthetic device;
28. services arising from voluntary self - inflicted injury or illness, whether the patient is sane or insane;
29. house calls for dental services;
30. training and/or appliances to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
31. periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;
32. temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
33. replacement of existing crowns, bridges or dentures that are less than five (5) years old;
34. charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
35. duplicate dentures, prosthetic devices or any other duplicate appliance;

36. any and all Implant services that have not been prior authorized and approved by a Dental Plan Administrator. Implants that are used as an abutment, double abutment, or bone anchor to support or hold a fixed bridge, orthodontic appliance, removable prosthesis, or oral-maxillofacial prosthesis are not covered;

37. Caries Risk Management — CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). For each risk level the following is covered:
    A. "high risk" will be allowed up to four (4) fluoride varnish treatments during the Calendar Year along with their biannual cleanings;
    B. "medium risk" will be allowed up to three (3) fluoride varnish treatments in addition to their biannual cleanings; and
    C. "low risk" will be allowed up to two (2) fluoride varnish treatments in addition to biannual cleanings.

    When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

Orthodontic Exclusions

1. treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
2. Treatment in Progress (after banding) at inception of eligibility;
3. surgical Orthodontics incidental to Orthodontic treatment;
4. treatment for myofunctional therapy;
5. changes in treatment necessitated by an accident;
6. re-treatment of Orthodontic cases when a Dental Plan Administrator concurs with the professional judgment of the attending Dentist that there is a poor prognosis;
7. treatment for TMJ (temporomandibular joint) disorder or dysfunction;
8. ceramic braces which are considered to be cosmetic;
9. x-rays for Orthodontic purposes (to include full mouth screen and cephalometrics);
10. replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
11. treatment which is received in more than one course of treatment, or which is not received in consecutive months, or treatment exceeding twenty-four (24) consecutive months;
12. in the event of a Member's loss of coverage for any reason, if at the time of loss of coverage the Member is still receiving Orthodontic treatment during the twenty-four (24) month treatment period, the Member and not the Dental Plan Administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's billed charges, prorated for the number of months remaining.

If the Member elects to use invisalign®, lingual or invisible braces, sapphire or clear braces, additional costs beyond what BSC will pay for "standard" Orthodontic system of brackets and wires will be paid by the Member.

See the Grievance Process in your Evidence of Coverage for information on filing a grievance and your right to seek assistance from the Department of Managed Health Care.

Medical Necessity Exclusion

All Services must be of Medical Necessity. The fact that a Dentist or other Participating Dentist may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Medical Necessity even though it is not specifically listed as an exclusion or limitation, Blue Shield may limit or exclude Benefits for services which are not of Medical Necessity.

Limitations

The following services, if listed on the Summary of Benefits, will be subject to Limitations as set forth below:

1. one (1) in a six (6) month period:
    A. periodic oral exam;
    B. routine prophylaxis;
    C. fluoride treatment;
    D. bitewing x-rays (maximum four (4) per year:
    E. tissue conditioning;
    F. recementations if the crown or inlay was provided by other than the original Dentist; not eligible if the Dentist is doing the recementation of a service he/she provided within twelve (12) months;
    G. Periodontic maintenance.
2. one (1) in twelve (12) months:
    A. denture (complete or partial) reline;
    B. oral cancer screening;
    C. topical fluoride varnish (coverage limited to three (3) applications, when used as a therapeutic application in patients with a moderate-to-high carries risk).
3. one (1) in twenty-four (24) months:
    A. full mouth debridement;

B. gingival flap surgery per quad;
C. diagnostic casts;
D. sealants;
E. occlusal guards.

4. one (1) in thirty-six (36) months:
   A. mucogingival surgery per area;
   B. osseous surgery per quad;
   C. gingival flap surgery per quad;
   D. gingivectomy per quad;
   E. gingivectomy per tooth;
   F. bone replacement grafts for periodontal purposes per site;
   G. guided tissue regeneration for periodontal purposes per site;
   H. full mouth series and panoramic x-rays;
   I. intraoral x-rays – complete series including bitewings.

5. one (1) in a five (5) year period:
   A. single crowns and onlays;
   B. single post and core buildups;
   C. crown buildup including pins;
   D. prefabricated post and core;
   E. cast post and core in addition to crown;
   F. complete dentures;
   G. partial dentures;
   H. fixed partial denture (bridge) pontics;
   I. fixed partial denture (bridge) abutments;
   J. abutment post and core buildups;
   K. diagnostic cast.

6. referral to a specialty care Dentist is limited to Orthodontics, Oral Surgery, Periodontics, Endodontics and Pedodontics.

7. coverage for referral to a pediatric specialty care Dentist is covered up to the age of six (6) and is contingent on Medical Necessity. However, exceptions for physical or mental disabilities or medically compromised children six (6) years and over, when confirmed by a physician, may be considered on an individual basis with prior approval.

8. space maintainers - only eligible for Members when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never, develop.

9. Orthodontic treatment to correct malocclusion is limited to one (1) continuous course of treatment per employee, spouse and eligible child(ren). Treatment may extend longer than twenty-four (24) months. However, payment for Orthodontic treatment is made in installments and will be prorated and distributed within twenty-four (24) consecutive months. If for any reason Orthodontic services are terminated or coverage is terminated before completion of the approved Orthodontic treatment, the responsibility of the Dental Plan Administrator will cease with payment through the month of termination.

10. sealants – one (1) per tooth per two (2) year period through the end of the month in which the Member turns nineteen (19) on permanent first and second molars.

11. child fluoride (including fluoride varnish) and child prophylaxis – one (1) per six (6) month period through the end of the month in which the Member turns nineteen (19).

12. in the case of a dental emergency involving pain or a condition requiring immediate treatment occurring more than fifty (50) miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an out-of-network Dentist up to the difference between the out-of-network Dentist's charge and the Member Copayment up to a maximum of fifty dollars ($50) for each emergency visit.

13. Oral Surgery services are limited to removal of teeth, bony protuberances and frenectomy.

14. an Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the Dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.

15. general or IV sedation is covered for
   A. 3 or more surgical extractions;
   B. any number of Medically Necessary impactions;
   C. full mouth or arch alveoloplasty;
   D. surgical root recovery from sinus;
   E. medical problem contraindicates local anesthesia;

   General or IV sedation is not a covered benefit for dental phobic reasons.

16. scaling and root planing – covered once for each of the four quadrants of the mouth in a twenty-four (24) month period. Scaling and root planing is limited to two (2) quadrants of the mouth per visit.

17. restorations, crowns, inlays and onlays - covered only if necessary to treat diseased or accidentally fractured teeth.

18. root canal treatment – one (1) per tooth per lifetime.

19. root canal retreatment – one (1) per tooth per lifetime.

20. pulpal therapy – through age five (5) on primary anterior teeth and through age eleven (11) on primary posterior teeth.

21. for mucogingival surgeries, one site is equal to two consecutive teeth or bounded spaces.

22. cone Beam CT (D0367) is a Benefit only when placing an Implant. This procedure cannot be used for Orthodontics or Periodontics. This is a once in a lifetime benefit and is limited to projection of upper and lower jaws only.

23. Implants – When a Benefit of your Plan, single tooth implant is offered for initial replacement of any missing single tooth except second and third molars and lower anterior teeth. Failed implant, second and third molar and lower anterior tooth replacement are not included. Benefits include the surgical implant placement, bone grafting to the site (if required), abutment that screws into the implant body (if one is utilized) and the prosthetic crown that is supported by the surgical implant. Benefits are provided for the maintenance, repair and removal of the implant;

24. you must be age twenty-one (21) years old or older to be eligible for dental Implant Benefits due to continued growth and development of the mid face and jaws. If there are bilaterally missing teeth and/or non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If there are more than three teeth missing and/or more than three non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If the Member elects a different procedure, payment will be based on the partial denture Benefit.

VII. Service Area and Eligibility

Service Area

The Service Area of this Plan is identified in the Plan Dental Directory. Within the Service Area, Members will be entitled to receive all Covered Services specified in the Summary of Benefits. The Plan will not pay for Dental Care Services that are (a) not Covered Services, (b) not provided by, or referred and authorized by the Member's Dental Provider, and/or (c) not referred and authorized by the Plan, where applicable. The Member will be required to pay for the cost of such services received.

Within the Service Area, Members should contact their designated Dental Provider for Emergency Services. Out-of-area Emergency Services are covered by the Plan subject to some limitations, as described in the section entitled "Choice of Dental Provider".

Eligibility

If you are an Employee and reside or work in the Service Area, you are eligible for coverage as a Subscriber the day following the date you complete the applicable waiting period established by your Employer. Your spouse or Domestic Partner and all your Dependent children who live or work in the Service Area are eligible at the same time.

Newborn infants of the Subscriber, spouse, or his or her Domestic Partner will be eligible immediately after birth for the first 31 days. A child placed for adoption will be eligible immediately upon the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Subscriber's, spouse's or Domestic Partner's right to control the child's dental care. Evidence of such control includes a health facility minor release report, a medical authorization form, or a relinquishment form. In either instance, in order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to and received by Blue Shield within 31 days of the birth or placement for adoption.

A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship, if an application is submitted within 31 days of becoming eligible.

You may add newly acquired Dependents and yourself to the Plan by submitting an application within 31 days from the date of acquisition of the Dependent:

1. to continue coverage of a newborn or child placed for adoption;

2. to add a spouse after marriage or add a Domestic Partner after establishing a domestic partnership;

3. to add yourself and spouse following the birth of a newborn or placement of a child for adoption;

4. to add yourself and spouse after marriage;

5. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

A completed health statement may be required with the application. Coverage is never automatic; an application is always required.

If both partners in a marriage or domestic partnership are eligible to be Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition,

may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Subscriber for support and maintenance, and (2) the Subscriber must submit a physician's written certification from the Member's physician of such disabling condition. Blue Shield or the Employer will notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician's written certification within 60 days of the request for such information by the Employer or by Blue Shield. Proof of continuing disability and dependency must be submitted by the Employee as requested by Blue Shield but not more frequently than 2 years after the initial certification and then annually thereafter.

Subject to the requirements described under the Group Continuation Coverage provision in this booklet, if applicable, an Employee and his or her Dependents will be eligible to continue group coverage under this Plan when coverage would otherwise terminate.

Effective Date of Coverage

Coverage will become effective at 12:01 a.m. Pacific Standard Time on the eligibility date established by your Employer.

If, during the initial enrollment period, you have included your eligible Dependents on your application to Blue Shield, their coverage will be effective on the same date as yours. If application is made for Dependent coverage within 31 days after you become eligible, their effective date of coverage will be the same as yours.

When you do not enroll yourself or your Dependents during the initial enrollment period and later apply for coverage, you and your Dependents will be considered to be late enrollees. When late enrollees decline coverage during the initial enrollment period, they will be eligible the earlier of, 12 months from the date of application for coverage or at the Employer's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

You and your Dependents will not be considered to be late enrollees if either you or your Dependents lose coverage under another Employer health plan and you apply for coverage under this Plan within 31 days of the date of loss of coverage. You will be required to furnish Blue Shield written proof of the loss of coverage.

Once each Calendar Year, your Employer may designate a time period as an annual Open Enrollment Period. During that time, you and your Dependents may elect to become a Member of the Plan. A completed application form, which also indicates your choice of a Dental Provider, must be forwarded to Blue Shield during the Open Enrollment Period and your coverage will become effective on the first day of the month following the Open Enrollment Period.

Any individual who becomes eligible at a time other than during the annual Open Enrollment Period (e.g., newborn, child placed for adoption, child acquired by legal guardianship, new spouse or Domestic Partner, newly hired or newly transferred Employees) must complete an application form within 31 days of becoming eligible.

Coverage for a newborn child will become effective on the date of birth. Coverage for a child placed for adoption will become effective on the date the Subscriber, spouse or Domestic Partner has the right to control the child's dental care, following submission of evidence of such control (a health facility minor release report, a medical authorization form or a relinquishment form). In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by Blue Shield within 31 days. A Dependent spouse becomes eligible on the date of marriage. A Domestic Partner becomes eligible on the date a domestic partnership is established as set forth in the Definitions section of this booklet. A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship.

If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child, under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the California Family Code.

Prepayment Fee

The monthly Dues for you and your Dependents are indicated in your Employer's group Contract. The initial Dues are payable on the effective date of the group Contract, and subsequent Dues are payable on the same date (called the transmittal date) of each succeeding month. Dues are payable in full on each transmittal date and must be made for all Subscribers and Dependent.

All Dues required for coverage for you and your Dependents will be handled through your Employer, and must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this group Contract up to the date immediately preceding the next transmittal date, but not thereafter.

The Dues payable under this Plan may be changed from time to time, for example, to reflect new Benefit levels. Your Employer will receive notice from the Plan of any changes in Dues at least 60 days prior to the change. Your Employer will then notify you immediately. Note: This

paragraph does not apply to a Member who is enrolled under a Contract where monthly Dues automatically increase, without notice, the first day of the month following an age change that moves the Member into the next higher age category.

VIII. Duplicate Coverage, Reductions - Third Party Liability and Coordination of Benefits

Limitations for Duplicate Coverage

When you are eligible for Medi-Cal

Your Blue Shield of California Plan always provides Benefits first. Medi-Cal always provides benefits last.

When you are a qualified veteran

If you are a qualified veteran your Blue Shield of California Plan will pay the reasonable value or Blue Shield of California's or a Dental Plan Administrator's Allowable Amount for Covered Services provided to you at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield of California Plan will pay the reasonable value or Blue Shield of California's or a Dental Plan Administrator's Allowable Amount for Covered Services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Blue Shield group Plan will equal, but not exceed, what Blue Shield or a Dental Plan Administrator would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's or a Dental Plan Administrator's Allowed Amount).

Contact the Member Services department at the number shown in the "Member Services" section of this booklet if you have any questions about how Blue Shield or a Dental Plan Administrator coordinates your group Plan benefits in the above situations.

Exception for Other Coverage

A Participating Dentist may seek reimbursement from other third party payers for the balance of its reasonable charges for services rendered under this Plan.

Claims and Services Review

Blue Shield and a Dental Plan Administrator reserve the right to review all claims and services to determine if any exclusions or other limitations apply. Blue Shield or a Dental Plan Administrator may use the services of Dentist consultants, peer review committees of professional societies, and other consultants to evaluate claims.

Reductions - Third Party Liability

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield or a Dental Plan Administrator shall, with respect to services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for services provided to the Member from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

This right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Member has been "made whole" by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The Member is required to:

1. Notify Blue Shield or a Dental Plan Administrator in writing of any actual or potential claim or legal action which such Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,

4. Provide a lien calculated in accordance with California Civil Code Section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield and a Dental Plan Administrator, in writing, within ten (10) days after any Recovery has been obtained.

A Member's failure to comply with 1. through 5. above shall not in any way act as a waiver, release or relinquishment of the rights of Blue Shield or a Dental Plan Administrator.

Coordination of Benefits

Coordination of Benefits is designed to provide maximum coverage for required Dental Care Services at the lowest cost by avoiding excessive payments.

When a person who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the Members of a group are entitled to payment of or reimbursement for dental expenses, such person will not be permitted to make a "profit" on a disability by collecting Benefits in excess of actual value or cost during any Calendar Year.

Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are incurred for Dental Care Services covered under at least one of the plans involved) up to the maximum Benefit value or amount payable by each plan separately.

If the Member is also entitled to Benefits under any of the conditions as outlined under the "Limitations for Duplicate Coverage" provision, Benefits received under any such condition will not be coordinated with the Benefits of this Plan.

The following rules determine the order of Benefit payments: When the other plan does not have a coordination of Benefits provision it will always provide its Benefits first. Otherwise, the plan covering the patient as an Employee will provide its Benefits before the plan covering the patient as a Dependent.

The plan which covers the Dependent child of a person whose date of birth, (excluding year of birth), occurs earlier in a Calendar Year, shall determine its Benefits before a plan which covers the Dependent child of a person whose date of birth, (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its Benefits before the other or in each plan determining its Benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of Benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent shall determine their respective Benefits in the following order:

   First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

2. Notwithstanding (1) above, if there is a court decree which otherwise establishes financial responsibility for the dental or other health care expenses of the child, then the plan which covers the child as a Dependent of the parent with that financial responsibility shall determine its Benefits before any other plan which covers the child as a Dependent child.

If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its Benefits first, provided that:

1. a plan covering a patient as a laid-off or retired Employee, or as a Dependent of such an Employee, shall determine its Benefits after any other plan covering that person as an Employee, other than a laid-off or retired Employee, or such Dependent; and

2. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its Benefits after the other, then the provisions of (1) above shall not apply.

If this Plan is the primary carrier with respect to a covered person, then this Plan will provide its Benefits without reduction because of Benefits available from any other plan.

When the Plan is secondary in the order of payments, the Plan's benefits are determined after those of the primary plan and may be reduced because of the primary plan's benefits. In such cases, the Plan pays the lesser of either the amount that it would have paid in the absence of any other coverage, or the enrollee's total out-of-pocket cost payable under the primary plan for benefits covered under the Plan.

When this Plan is secondary in the order of payments, and Blue Shield is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will provide the Benefits that would be due as if it were the primary plan, provided that the covered person (1) assigns to Blue Shield the right to receive payments from the other plan to the

extent of the difference between the value of the Benefits which Blue Shield actually provides and the value of the Benefits that Blue Shield would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with Blue Shield and a Dental Plan Administrator in obtaining payment of Benefits from the other plan, and (3) allows Blue Shield and a Dental Plan Administrator to obtain confirmation from the other plan that the Benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another plan, Blue Shield may pay to the other plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as Benefits paid under this Plan. Blue Shield shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by Blue Shield in excess of the maximum amount of payment necessary to satisfy these provisions, Blue Shield shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

Blue Shield may release to or obtain from any organization or person any information which Blue Shield considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any person claiming Benefits under this Plan shall furnish Blue Shield with such information as may be necessary to implement these provisions.

IX. Group Continuation Coverage

Group Continuation Coverage

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual dental insurance could result in a higher premium or you could be denied coverage entirely.

Applicable to Members when the Subscriber's Employer (Contractholder) is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Subscriber's Employer should be contacted for more information.

In accordance with COBRA as amended and Cal-COBRA, a Member will be entitled to elect to continue group coverage under this Plan if the Member would lose coverage otherwise because of a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The Benefits under the group continuation of coverage will be identical to the Benefits that would be provided to the Member if the Qualifying Event had not occurred (including any changes in such coverage).

Note: A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any pre-existing condition. Under COBRA, a Member is entitled to Benefits if at the time of the qualifying event such Member is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences:

1. With respect to the Subscriber:
   a. the termination of employment (other than by reason of gross misconduct); or
   b. the reduction of hours of employment to less than the number of hours required for eligibility.
2. With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be added as Dependents, provided the Contractholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):

   *Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

   a. the death of the Subscriber; or
   b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
   c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or

d. the divorce or legal separation of the Dependent spouse from the Subscriber or termination of the domestic partnership; or

e. the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or

f. a Dependent child's loss of Dependent status under this Plan.

3. For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, when the Employer files for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4. Such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1. With respect to COBRA enrollees

   The Member is responsible for notifying the Employer of divorce, legal separation, or a child's loss of Dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

   The Employer is responsible for notifying its COBRA administrator (or Plan administrator if the Employer does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, the Subscriber's Medicare entitlement, or the Employer's filing for reorganization under Title XI, United States Code.

   When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under this Plan.

   The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

   If the Member does not notify the COBRA administrator within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA enrollees:

   The Member is responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership or a child's loss of Dependent status under this Plan. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

   The Employer is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the Qualifying Event.

   When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under this Plan. The Member must then give Blue Shield notice in writing of the Member's election of continuation coverage within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage and (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

   If the Member does not notify Blue Shield within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

   If this Plan replaces a previous group plan that was in effect with the Employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this Plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

Duration and Extension of Continuation of Group Coverage

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this Plan for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36

months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the Qualifying Event has occurred which originally entitled the Member to continue group coverage under this Plan.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

Notification Requirements

The Employer or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact Blue Shield for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield at least 30 days before COBRA termination.

Payment of Dues

Dues for the Member continuing coverage shall be 102 percent of the applicable group Dues rate if the Member is a COBRA enrollee or ll0 percent of the applicable group Dues rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the Dues for months 19 through 29 shall be 150 percent of the applicable group Dues rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, Dues for Cal-COBRA coverage shall be 110 percent of the applicable group Dues rate for months 30 through 36.

If the Member is enrolled in COBRA and is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all Dues contributions to Blue Shield in the manner and for the period established under this Plan.

Cal-COBRA enrollees must submit Dues directly to Blue Shield of California. The initial Dues must be paid within 45 days of the date the Member provided written notification to the Plan of the election to continue coverage and be sent to Blue Shield by first-class mail or other reliable means. The Dues payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45 day period will disqualify the Member from continuation coverage.

Effective Date of the Continuation of Coverage

The continuation of coverage will begin on the date the Member's coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as Dues are timely paid.

Termination of Continuation of Group Coverage

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this Group Dental Service Contract (if the Employer continues to provide any group benefit plan for Employees, the Member may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required Dues to the COBRA administrator or the Employer or to Blue Shield of California as applicable. Coverage will end as of the end of the period for which Dues were paid;
3. the Member becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation provision that applies to the Member;
4. the Member becomes entitled to Medicare;
5. the Member no longer resides in Blue Shield's Service Area;
6. the Member commits fraud or deception in the use of the services of this Plan.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

Continuation of Group Coverage for Members on Military Leave

Continuation of group coverage is available for Members on military leave if the Member's Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their Employer for information about their rights under the (USERRA). Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, and Labor Code requirements for Medical Disability.

X. Termination of Benefits and Cancellation Provisions

Termination of Benefits

Coverage for you or your Dependents terminates at 11:59 p.m. Pacific Standard Time on the earliest of these dates: (a) the date the Group Dental Service Contract is discontinued, (b) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and your Employer, (c) the date as indicated in the Notice of End of Coverage that is sent to the Employer (see "Cancellation for Non-Payment of Dues - Notices"), or (d) on the last day of the month in which you or your Dependents become ineligible. A spouse also becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment, or dissolution of marriage from the Subscriber. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

Except as specifically provided under the Group Continuation Coverage provisions, if applicable, there is no right to receive Benefits for services provided following termination of this group contract. The Group Dental Service Contract is issued for a one year period. Your Employer will notify you if your dental coverage will not be renewed after the period of this Contract.

If you cease work because of retirement, disability, leave of absence, temporary layoff or termination, see the Group Continuation Coverage provisions described in this booklet for information on continuation of coverage.

If your Employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for Family leave under the terms of such Act(s), your payment of Dues will keep your coverage in force for such period of time as specified in such Act(s). Your Employer is solely responsible for notifying you of the availability and duration of Family leaves.

If written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 31 days following that Dependent's effective date of coverage, Benefits under this Plan will be terminated on the 31st day at 11:59 p.m. Pacific Time.

Additionally, Blue Shield may terminate coverage if:

1. There is a violation of a material contract provision relating to Employer contribution or group participation rates by the Contractholder/Employer;
2. Blue Shield terminates a particular product or all products offered in the large group market as permitted or required by law. If Blue Shield discontinues offering a particular product in a market, Blue Shield will send you written notice at least 90 days before the product terminates. If Blue Shield discontinues offering all products to groups in the large group market, Blue Shield will send you written notice at least 180 days before the Contract terminates;
3. A Member or Employer ceases to be a member of a guaranteed association.

Reinstatement

Only your Employer may reinstate coverage in the event of cancellation. If you cancel or your coverage is terminated, you must wait until the Open Enrollment Period established by your Employer to re-apply.

Cancellation Without Cause

The group Contract also may be cancelled by your Employer at any time provided written notice is given to Blue Shield to become effective upon receipt, or on a later date as may be specified on the notice.

Cancellation for Non-Payment of Dues - Notices

Blue Shield may cancel this Group Dental Service Contract for non-payment of Dues. If your Employer fails to pay the required Dues when due, coverage will end the day following the 60-day grace period. Your Employer will be liable for all Dues accrued while this Plan continues in force including those accrued during the 60-day grace period. Blue Shield of California will send you and your Employer a Notice of End of Coverage no later than five calendar days after the date of coverage ends.

Cancellation/Rescission for Fraud or Intentional, Misrepresentations of Material Fact

Blue Shield may cancel or rescind the group contract for fraud or intentional misrepresentation of material fact by your Employer, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative.

If you are undergoing treatment for an ongoing condition and the group Contract is cancelled for any reason, including non-payment of Dues, no Benefits will be provided.

Fraud or intentional misrepresentations of material fact on an application or a health statement (if a health statement is required by the Employer) may, at the discretion of Blue Shield, result in the cancellation or rescission of this Plan. A rescission voids the Contract retroactively as if it was never effective. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to your Employer prior to any rescission. Your employer must provide you with a copy of the Notice of Cancellation, Rescission or Nonrenewal.

In the event the Dental Services Contract is rescinded or cancelled, it is your Employer's responsibility to notify you of the rescission or cancellation. Cancellation is effective on the date specified in the Notice of Cancellation, Rescission or Nonrenewal and the Notice of End of Coverage.

Plan Changes

The Benefits of this Plan, including but not limited to Covered Services and Copayments, are subject to change at any time. Blue Shield will provide at least 60 days' written notice of any such change.

Benefits for services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

Right of Cancellation

If you are making any contributions toward coverage for yourself or your Dependents, you may cancel such coverage to be effective at the end of any period for which Dues have been paid.

Any Dues paid to Blue Shield for a period extending beyond the cancellation date will be refunded to your Employer. Your Employer will be responsible to Blue Shield for unpaid Dues prior to the date of cancellation.

Blue Shield will honor all timely filed claims for Covered Dental Care Services provided prior to the effective date of cancellation.

See the Cancellation and Rescission provision for termination for fraud or intentional misrepresentations of material fact.

XI. Member Services and Grievance Process

Member Services

If you have a question about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may call your Dental Member Services Department at:

In California:	1-800-585-8111
Outside California:	1-800-323-7201

Member Services can answer many questions over the telephone.

You may write to:

Dental Plan Administrator
Dental Member Services
425 Market St., 15th Floor
San Francisco, CA 94105

Note: A Dental Plan Administrator has established a procedure for our Members to request an expedited decision. A Member, physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. A Dental Plan Administrator shall make a decision and notify the Member and physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact Dental Member Services Department at the number listed above.

Grievance Process

Members, a designated representative, or a provider on behalf of the Member, may contact the Dental Member Services Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Members may contact the Dental Member Services Department at the telephone number as noted

below. If the telephone inquiry to the Dental Member Services Department does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Dental Member Services Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this form from the Dental Member Services Department. If the Member wishes, the Dental Member Services staff will assist in completing the grievance form. Completed grievance forms must be mailed to a Dental Plan Administrator at the address provided below. The Member may also submit the grievance form to the Dental Member Services Department online by visiting http://www.blueshieldca.com.

1-800-585-8111

Blue Shield of California
Dental Plan Administrator
425 Market Street, 15th Floor
San Francisco, CA 94105

A Dental Plan Administrator will acknowledge receipt of a written grievance within 5 calendar days. Grievances are resolved within 30 days.

The grievance system allows Members to file grievances within 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Member Services section for information on the expedited decision process.

XII. Other Provisions

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at **1-800-424-6521** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in Nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site, **(http://www.hmohelp.ca.gov)**, has complaint forms, IMR application forms, and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment for you or your Dependents and you feel that such action was due to health or utilization of Benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

Public Policy Participation Procedure

This procedure enables you to participate in establishing public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its Employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide Dental Care Services to them, their families, and the public (California Health and Safety Code, Section 1369).

At least one third of the Board of Directors of Blue Shield is comprised of Subscribers who are not Employees, providers, sub-contractors or group contract brokers and who do not have financial interests in Blue Shield.

The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Telephone: (510) 607-2065

Please follow the following procedure:

1. Your recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of your letter.
2. Your name, address, phone number, Subscriber number, and group number should be included with each communication.
3. The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter.
4. Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of

Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within 10 business days after the minutes have been approved.

Grace Period

After payment of the first Dues, the Contractholder is entitled to a grace period of 60 days for the payment of any Dues due. During this grace period, the Contract will remain in force. However, the Contractholder will be liable for payment of Dues accruing during the period the Contract continues in force.

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Member (deductibles, Copayments, Coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

Confidentiality of Personal and Health Information

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Blue Shield will not disclose this information without your authorization, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Member Services Department at the number listed in the Member Services section of this booklet, or by accessing Blue Shield of California's internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:

Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

Access to Information

Blue Shield of California may need information from medical or Dental Providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Contract. You agree that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. You agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary Authorizations) and to cooperate by providing Blue Shield with information in your possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Non-Assignability

Benefits of this Plan are not assignable.

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

Participating Dentist Network

A Dental Plan Administrator has established a network of Dental Providers and other dental health professionals in your Service Area.

The Dental Provider(s) you and your Dependents select will provide telephone access 24 hours a day, seven days a week so that you can obtain assistance and prior approval of necessary Dental Care Services. The Directory of Dental Providers in your Service Area indicates their location and phone numbers.

Independent Contractors

Providers are neither agents nor Employees of the Plan but are independent contractors. In no instance shall Blue Shield of California be liable for the negligence, wrongful acts, or omissions of any person receiving or providing services, including any Dentist, physician, hospital, or other provider or their Employees.

XIII. DEFINITIONS

Terms used throughout this Evidence of Coverage are defined as follows:

Accidental Injury - definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

Allowable Amount - the amount a Participating Dentist agrees to accept as payment from a Dental Plan Administrator or the billed amount for Non-Participating Dentists.

Alternate Benefit Provision (ABP) - a provision that allows benefit paid to be based on an alternate procedure, which is professionally acceptable and more cost effective.

Authorization - the procedure for obtaining the Plan's prior approval for all services provided to Members under the Contract other than your Dental Provider and Emergency Services.

Benefits (Covered Services) - those Services which a Member is entitled to receive pursuant to the terms of their Group Dental Service Contract.

Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. on January 1 of the next year.

Close Relative - the spouse, Domestic Partner, child, brother, sister, or parent of a Subscriber or Dependent.

Coinsurance - the percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Copayment - the specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Cosmetic Procedure - any surgery, service, appliance, or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasing or unsightly.

Covered Services (Benefits) - those Services which a Member is entitled to receive pursuant to the terms of their Group Dental Service Contract.

Dental Care Services - necessary treatment on or to the teeth or gums, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

Dental Center - means a Dentist or a dental practice (with one or more Dentists) which has contracted with a Dental Plan Administrator to provide dental care Benefits to Members and to diagnose, provide, refer, supervise, and coordinate the provision of all Benefits to Members in accordance with this Contract.

Dental Plan Administrator (DPA) - Blue Shield of California has contracted with a Dental Plan Administrator (DPA). A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of dental services through a network of Participating Dentists and Dental Centers.

Dental Provider (Participating Dentist) - means a Dentist or other provider appropriately licensed to provide Dental Care Services who contracts with a Dental Center to provide Benefits to Plan Members in accordance with their Dental Services Contract.

Dentist - a duly licensed Doctor of Dental Surgery or other practitioner who is legally entitled to practice dentistry in the state of California.

Dependent -

1. a Subscriber's legally married spouse or Domestic Partner who is:
   a. not covered for Benefits as a Subscriber; and
   b. not legally separated from the Subscriber;

   or,
2. a Subscriber's Domestic Partner, who is not covered for Benefits as a Subscriber;

   or,
3. a child of, adopted by, or in legal guardianship of the Subscriber, spouse or Domestic Partner, who is unmarried and is not in a domestic partnership. This category includes any stepchild or child placed for

adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber and who is less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by the Plan as a Dependent and has maintained membership in accordance with the contract.

Note: Children of Dependent children (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner) are not Dependents unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:

    a. the child may be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance and be incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition;

    b. the Subscriber, spouse, or Domestic Partner submits to Blue Shield a physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and

    c. thereafter, certification of continuing disability and dependency from a physician is submitted to Blue Shield on the following schedule:

        (1) within 24 months after the month when the Dependent would otherwise have been terminated; and

        (2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

Domestic Partner - an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1. Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;
2. The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
3. The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
4. Both partners are capable of consenting to the domestic partnership; and
5. If required under your Employer's written policy, both partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

Dues - the monthly pre-payment that is made to the Plan on behalf of each Member.

Elective Dental Procedure - any dental procedures which are unnecessary to the dental health of the patient, as determined by a Participating Dentist.

Emergency Services - services provided for an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part;
4. subjecting the Member to undue suffering.

Employee - an individual who meets the eligibility requirements set forth in the Group Dental Service Contract between Blue Shield of California and your Employer.

Employer (Contractholder) - any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 2 Employees and that is actively engaged in business or service, in which a bona fide Employer-Employee relationship exists, in which the majority of Employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

Endodontics - Dental Care Services specifically related to necessary procedures for treatment of disease of the pulp chamber and pulp canals, not requiring hospitalization.

Experimental or Investigational in Nature - any treatment, therapy, procedure, drug or drug usage, facility

or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical/dental standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical/dental standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

Family - the Subscriber and all enrolled Dependents.

Group Dental Service Contract (Contract) - the Contract issued by Blue Shield to the Contractholder that establishes the Benefits which Members are entitled to receive from the Plan.

Implants - artificial materials including synthetic bone grafting materials which are implanted into, onto or under bone or soft tissue, or the removal of Implants (surgically or otherwise).

Medical Necessity (Medically Necessary)
Benefits are provided only for services that are Medically Necessary.

1. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted national and California dental standards to treat illness, injury or dental condition, and which, as determined by the Dental Plan Administrator, are:
    a. consistent with the Dental Plan Administrator's dental policy;
    b. consistent with the symptoms or diagnosis;
    c. not furnished primarily for the convenience of the patient, the attending Dentist or other provider;
    d. furnished at the most appropriate level which can be provided safely and effectively to the patient; and
    e. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or dental condition.

Member - either a Subscriber or Dependent.

Non-Participating Dentist - a Dental Center, Plan Specialist, or other Dental Provider who has not signed a service contract with a Dental Plan Administrator to provide dental services to Subscribers.

Open Enrollment Period - that period of time set forth in the Contract during which eligible individuals and their Dependents may enroll in the Plan.

Oral Surgery - Dental Care Services specifically related to the diagnosis and the surgical and adjunctive treatment of diseases, injuries and defects of the mouth, jaws and associated structures.

Orthodontics (Orthodontic) - Dental Care Services specifically related to necessary services for the treatment for malocclusion and the proper alignment of teeth.

Palliative Treatment - therapy designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.

Participating Dentist - a Dental Center, Participating Specialist, or other Dental Provider who has an agreement with a Dental Plan Administrator to provide Plan Benefits to Members.

Participating Specialist - a Dentist who is licensed or authorized by the State of California to provide specialized Dental Care Services as recognized by the appropriate specialty board of the American Dental Association and who has an agreement with a Dental Plan Administrator to provide Covered Services to Members on referral by Dental Provider.

Pedodontics - Dental Care Services related to the diagnosis and treatment of conditions of the teeth and mouth in children.

Periodontics - Dental Care Services specifically related to necessary procedures for providing treatment of disease of gums and bones supporting the teeth, not requiring hospitalization.

Physician - an individual licensed and authorized to engage in the practice of medicine (M.D.) or osteopathy (D.O.).

Plan - the Blue Shield Dental Plan.

Prosthodontist - Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth.

Service Area - that geographic area served by the Plan.

Subscriber - an individual who satisfies the eligibility requirements of the Dental Services Contract, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this Contract.

Surcharge - an additional fee which is charged to a Member for Dental Care Service which is not provided for in the

Dental Services Contract or disclosed in the Evidence of Coverage.

Treatment in Progress - partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken. Ongoing Orthodontic cases are not considered Treatment in Progress under this definition.

Customer Service

1-888-702-4171

The hearing impaired may call Blue Shield's Member Services Department through Blue Shield's toll-free TTY number at 1-800-241-1823.

Please send claims for Enhanced Dental Benefits for Pregnant Women to:

Blue Shield of California
Periodontal Coverage for Women During Pregnancy
P.O. Box 30567
Salt Lake City, UT 84130-0567

Please direct correspondence to:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540

W0054268-D0000183 (08/21)

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

• Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (including large print, audio, accessible electronic formats and other formats)

• Provides language services at no cost to people whose primary language is not English such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711) Fax:
(844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW. Room 509F, HHH Building

Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh íliníigó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)