



Evidence of Coverage

GOOD SAMARITAN HOSPITAL
01/01/2025
Dental HMO Elite 75



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Dental HMO Elite 75

(Available to groups of 101 and above)

Evidence of Coverage

Group

An independent member of the Blue Shield Association

Evidence of Coverage

Blue Shield of California Dental HMO Elite 75

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.

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Summary of Benefits

Group Dental Plan
DHMO Plan

Dental HMO Elite 75

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 Deductible (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.

Calendar Year Deductible	When using a Participating Dentist ³	
	Individual coverage	\$0 per individual
	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.

Calendar Year Benefit Maximum	When using a Participating Dentist ³	
	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
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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.

Blue Shield of California is an independent member of the Blue Shield Association

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

ADA Code	Services	When using a Participating ³ Dentist
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
D0170	Re-evaluation – limited, problem focused (not post-operative visit)	\$0
D0171	Re-evaluation – post operative visit	\$0
D0180	Comprehensive periodontal evaluation	\$0
D0210	Intraoral comprehensive 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
D0250	Extraoral – first 2D projection radiographic image created using a stationary radiation source, and detector	\$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
D0277	Vertical bitewings – 7 to 8 images	\$0
D0330	Panoramic radiograph film (once every 36 months)	\$0
D0350	2D oral/facial photographic images, non-orthodontic, obtained intraorally or extraorally	\$0
D0372	Intraoral tomosynthesis – comprehensive series of radiographic images	\$0
D0373	Intraoral tomosynthesis – bitewing radiographic image	\$0
D0374	Intraoral tomosynthesis – periapical radiographic image	\$0
D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	\$0
D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only	\$0
D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only	\$0
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$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
D0701	Panoramic radiographic - image capture only	\$0
D0702	2-D cephalometric radiographic image – image capture only	\$0
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	\$0
D0706	Intraoral – occlusal radiographic image – image capture only	\$0

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

ADA Code	Services	When using a Participating ³ Dentist
D0707	Intraoral – periapical radiographic image – image capture only	\$0
D0708	Intraoral – bitewing radiographic image – image capture only Image axis may be horizontal or vertical	\$0
D0709	Intraoral – comprehensive series of radiographic images – image capture only	\$0
Preventive services		
D1110	Prophylaxis – adult (twice every consecutive 12 months) – covered only by your primary care provider	\$0
D1110	Prophylaxis – adult (additional within the consecutive 12-month period) – covered only by your primary care provider	\$45
D1110	Enhanced dental cleaning for pregnant women	\$0
D1120	Prophylaxis – child (twice every consecutive 12 months) – covered only by your primary care provider	\$0
D1120	Prophylaxis – child (additional within the consecutive 12-month period) – covered only by your primary care provider	\$35
D1206	Topical application of fluoride varnish – three applications every 12 months when used as a therapeutic application in patients with a moderate-to-high-risk	\$5
D1208	Topical application of fluoride – excluding varnish – once every 6 months	\$0
D1310	Nutritional counseling for control of dental disease	\$0
D1320	Tobacco counseling for the control and prevention of oral disease	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant – per tooth	\$0
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth – child through age 18	\$0
D1353	Sealant repair-per-tooth. May not be charged by placing provider within 18 months of initial placement.	\$0
D1354	Interim caries arresting medicament application-per-tooth. Does not include dental fluoride varnish application.	\$0
D1355	Caries preventive medicament application – per tooth for primary prevention or remineralization. Medicaments applied do not include topical fluorides.	\$0
D1510	Space maintainer – fixed - unilateral - per quadrant	\$35
D1516	Space maintainer – fixed – bilateral, maxillary	\$45
D1517	Space maintainer – fixed – bilateral, mandibular	\$45
D1520	Space maintainer – removable - unilateral - per quadrant	\$35
D1526	Space maintainer – removable – bilateral, maxillary	\$55
D1527	Space maintainer – removable – bilateral, mandibular	\$55
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant	\$35
Restorative services		
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

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

ADA Code	Services	When using a Participating ³ Dentist
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, anterior	\$0
D2390	Resin-based composite – crown, anterior	\$50
D2391	Resin-based composite – one surface, posterior	\$65/tooth
D2392	Resin-based composite – two surfaces, posterior	\$85
D2393	Resin-based composite – three surfaces, posterior	\$100
D2394	Resin-based composite – four or more surfaces, posterior	\$120
Inlays/Onlays		
D2510	Inlay – metallic – one surface	\$80
D2520	Inlay – metallic – two surfaces	\$85
D2530	Inlay – metallic – three or more surfaces	\$90
D2542	Onlay – metallic – two surfaces	\$85
D2543	Onlay – metallic – three surfaces	\$90
D2544	Onlay – metallic – four or more surfaces	\$95
D2610	Inlay – porcelain/ceramic – one surface	\$175
D2620	Inlay – porcelain/ceramic – two surfaces	\$195
D2630	Inlay – porcelain/ceramic – three or more surfaces	\$210
D2642	Onlay – porcelain/ceramic – two surfaces	\$195
D2643	Onlay – porcelain/ceramic – three surfaces	\$205
D2644	Onlay – porcelain/ceramic – four or more surfaces	\$210
D2650	Inlay – resin-based composite – one surface	\$70
D2651	Inlay – resin-based composite – two surfaces	\$75
D2652	Inlay – resin-based composite – three or more surfaces	\$80
D2662	Onlay – resin-based composite – two surfaces	\$75
D2663	Onlay – resin-based composite – three surfaces	\$80
D2664	Onlay – resin-based composite – four or more surfaces	\$85
Crowns		
D2740	Crown – porcelain/ceramic	\$225/crown
D2750	Crown – porcelain fused to high noble metal	\$225/crown
D2751	Crown – porcelain fused to predominantly base metal	\$75/crown
D2752	Crown – porcelain fused to noble metal	\$175/crown
D2780	Crown – 3/4 cast high noble metal	\$225/crown
D2781	Crown – 3/4 cast predominantly base metal	\$75/crown
D2782	Crown – 3/4 cast noble metal	\$175/crown
D2783	Crown – 3/4 porcelain/ceramic	\$225/crown
D2790	Crown – full cast high noble metal	\$225/crown
D2791	Crown – full cast predominantly base metal	\$75/crown

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

ADA Code	Services	When using a Participating ³ Dentist
D2792	Crown – full cast noble metal	\$175/crown
D2794	Crown – titanium and titanium alloys	\$225/crown
D2794	Crown – titanium, includes full titanium and porcelain fused to titanium for molars	Add \$75 nonmolar copayment fee for porcelain fused to titanium crowns
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	\$0
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$0
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$0
D2920	Re-cement or re-bond crown	\$0
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	\$0
D2929	Prefabricated porcelain/ceramic crown – primary tooth (1 x per primary tooth)	\$100
D2930	Prefabricated stainless steel crown – primary tooth	\$0
D2931	Prefabricated stainless steel crown – permanent tooth	\$0
D2932	Prefabricated resin crown	\$50
D2933	Prefabricated stainless steel crown with resin window	\$50
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$55
D2940	Protective restoration	\$0
D2941	Interim therapeutic restoration –primary dentition	\$0
D2949	Restorative foundation for an indirect restoration	\$0
D2950	Core buildup, including any pins when required	\$0
D2951	Pin retention – per tooth, in addition to restoration	\$0
D2952	Post and core in addition to crown – indirectly fabricated	\$50
D2953	Each additional indirectly fabricated post – same tooth	\$0
D2954	Prefabricated post and core in addition to crown	\$30
D2955	Post removal	\$15
D2957	Each additional prefabricated post – same tooth	\$0
D2980	Crown repair necessitated by restorative material failure	\$50
D2981	Inlay repair necessitated by restorative material failure	\$25
D2982	Onlay repair necessitated by restorative material failure	\$35
D2990	Resin infiltration of incipient smooth surface lesions	\$0
Labial Veneers (replaced once every 5 years when Dentally Necessary)		
D2961	Labial veneer (resin laminate) – laboratory	\$250
D2962	Labial veneer (porcelain laminate) – laboratory	\$250
D2983	Veneer repair due to restorative material failure – not allowed to be charged by same provider within 24 months of the original restoration	\$50
D2989	Excavation of a tooth resulting in the determination of non-restorability	\$0

Alternative Crowns

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

ADA Code	Services	When using a Participating ³ Dentist
	Premium materials are frequently offered by dentists as alternatives to the standard porcelain/ceramic substrate and porcelain-fused-to-metal materials for dental restorations. These materials are marketed under different brand names and may be available through your Blue Shield of California Participating Provider at the copayments listed below. Crowns, bridges, Inlays, and Onlays, fabricated in these premium material alternatives and prepared and delivered on the same day are subject to an additional \$250.00 in-office lab fee.	
	Porcelain/ceramic substrate crown	
	CEREC, Full-Z, Bruxzir, Lava, PrismaTik	\$645
	CEREC Blue Block, e.Max, Procera	\$845
	Lava (layered), e.Max (layered), Procera (Layered)	\$900
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	\$675
	Occlusal Gold, Design, Synspar	\$675
	Endodontics (excluding final restorations)	
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	\$0
D3221	Pulpal debridement – primary and permanent tooth	\$15
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth	\$10
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth	\$15
D3310	Endodontic therapy – anterior tooth (excluding final restoration)	\$50
D3320	Endodontic therapy – premolar tooth (excluding final restoration)	\$70
D3330	Endodontic therapy – molar tooth (excluding final restoration)	\$150
D3331	Treatment of root canal obstruction – non-surgical access	\$150
D3332	Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth	\$50
D3346	Retreatment of previous root canal therapy – anterior	\$70
D3347	Retreatment of previous root canal therapy – bicuspid	\$100
D3348	Retreatment of previous root canal therapy – molar	\$190
D3351	Apexification/recalcification – initial visit	\$55
D3352	Apexification/recalcification – interim medication replacement	\$45
D3353	Apexification/recalcification – final visit (includes completed root canal)	\$55
D3355	Pulpal regeneration – initial visit	\$55
D3356	Pulpal regeneration – interim medication replacement	\$45
D3357	Pulpal regeneration – completion of treatment	\$55
D3410	Apicoectomy – anterior – first root	\$150
D3421	Apicoectomy – premolar – first root	\$150
D3425	Apicoectomy – molar – first root	\$200
D3426	Apicoectomy – each additional root	\$100
D3430	Retrograde filling – per root	\$100

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

ADA Code	Services	When using a Participating ³ Dentist
D3450	Root amputation – per root	\$75
D3471	Surgical repair of a root resorption – anterior – first root	\$150
D3472	Surgical repair of a root resorption – molar – for surgery on root of premolar tooth – first root. Does not include placement of restoration.	\$150
D3473	Surgical repair of a root resorption – molar – for surgery on root of molar tooth – first root. Does not include placement of restoration.	\$150
D3911	Intraorifice barrier	\$65
D3920	Hemisection, including any root removal (not including root canal therapy)	\$100
D3950	Canal preparation and fitting of preformed dowel or post	\$0
Periodontics		
D4210	Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces – per quadrant	\$40
D4211	Gingivectomy/gingivoplasty – one to three contiguous teeth or tooth bounded spaces – per quadrant	\$35
D4212	Gingivectomy/gingivoplasty – to allow access for restorative procedure – per tooth	\$20
D4240	Gingival flap procedure, including root planing – four or more teeth – per quadrant	\$275
D4241	Gingival flap procedure, including root planing – one to three teeth – per quadrant	\$195
D4249	Clinical crown lengthening – hard tissue. D4249, when performed the same day as impression will be considered to be D4212 – covered only when performed by the member's primary general dentist	\$100
D4260	Osseous surgery, including elevation of a full thickness flap and closure – four or more contiguous teeth or tooth bounded spaces – per quadrant	\$250
D4261	Osseous surgery, including elevation of full thickness flap and closure – one to three contiguous teeth or tooth bounded spaces – per quadrant	\$200
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	\$200
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	\$125
D4341	Periodontal scaling and root planing – four or more teeth – per quadrant	\$20
D4342	Periodontal scaling and root planing – one to three teeth – per quadrant	\$20
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)	\$0
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation, each additional	\$45/entire mouth
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	\$20
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue – per tooth	\$60
D4910	Periodontal maintenance (once every 6 months)	\$25
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	\$0
Removable prosthodontics		
D5110	Complete denture – maxillary	\$90/denture
D5120	Complete denture – mandibular	\$90/denture

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

ADA Code	Services	When using a Participating ³ Dentist
D5130	Immediate denture – maxillary	\$90/denture
D5140	Immediate denture – mandibular	\$90/denture
D5211	Maxillary partial denture – resin base, including retentive/clasping materials, rests and teeth	\$125/denture
D5212	Mandibular partial denture – resin base, including retentive/clasping materials, rests and teeth	\$125/denture
D5213	Maxillary partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests and teeth	\$125/denture
D5214	Mandibular partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests and teeth	\$125/denture
D5221	Immediate maxillary partial denture – resin base	\$125
D5222	Immediate mandibular partial denture – resin base	\$125
D5223	Immediate maxillary partial denture – metal framework	\$125
D5224	Immediate mandibular partial denture – metal framework	\$125
D5225	Maxillary partial denture – flexible base, including retentive/clasping materials, rests and teeth	\$125/denture
D5226	Mandibular partial denture – flexible base, including retentive/clasping materials, rests and teeth	\$125/denture
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$125
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$125
D5410	Adjust complete denture – maxillary	\$0
D5411	Adjust complete denture – mandibular	\$0
D5421	Adjust partial denture – maxillary	\$0
D5422	Adjust partial denture – mandibular	\$0
D5511	Repair broken complete denture base – mandibular	\$10 ⁶
D5512	Repair broken complete denture base – maxillary	\$10 ⁶
D5520	Replace missing or broken teeth – complete denture – each tooth	\$10 ⁶
D5611	Repair resin partial denture base – mandibular	\$10 ⁶
D5612	Repair resin partial denture base – maxillary	\$10 ⁶
D5621	Repair cast partial framework – mandibular	\$10 ⁶
D5622	Repair cast partial framework – maxillary	\$10 ⁶
D5630	Repair or replace broken retentive/clasping materials – per tooth	\$10 ⁶
D5640	Replace broken teeth – per tooth	\$10 ⁶
D5650	Add tooth to existing partial denture	\$10 ⁶
D5660	Add clasp to existing partial denture – per tooth	\$10 ⁶
D5670	Replace all teeth and acrylic on cast metal framework – maxillary	\$100 ⁶
D5671	Replace all teeth and acrylic on cast metal framework – mandibular	\$100 ⁶
D5710	Rebase – complete maxillary denture	\$40
D5711	Rebase – complete mandibular denture	\$40

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

ADA Code	Services	When using a Participating ³ Dentist
D5720	Rebase – partial maxillary denture	\$40
D5721	Rebase – partial mandibular denture	\$40
D5725	Rebase –hybrid prosthesis	\$40
D5730	Reline complete maxillary denture – direct	\$25/denture ⁷
D5731	Reline complete mandibular denture – direct	\$25/denture ⁷
D5740	Reline maxillary partial denture – direct	\$25/denture ⁷
D5741	Reline mandibular partial denture – direct	\$25/denture ⁷
D5750	Reline complete maxillary denture – indirect	\$25/denture ⁷
D5751	Reline complete mandibular denture – indirect	\$25/denture ⁷
D5760	Reline maxillary partial denture – indirect	\$25/denture ⁷
D5761	Reline mandibular partial denture – indirect	\$25/denture ⁷
D5765	Soft liner for complete or partial removable denture – indirect	\$10
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	\$40
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	\$40
D5850	Tissue conditioning – maxillary	\$10/denture unit
D5851	Tissue conditioning – mandibular	\$10/denture unit
D5876	Add metal substructure to new acrylic full denture (per arch) – use of metal substructure in removable complete dentures without a framework	\$200

Alternative dentures, full + partial, & relines

Dental offices may offer alternatives to standard complete and partial Dentures and relines. These alternatives are marketed under their specific brand names and may be available through your Blue Shield of California Participating Provider for the following copayments.

Complete Denture

Comfort Flex – Complete Upper Denture	\$550
Comfort Flex – Complete Lower Denture	\$550
Geneva – Complete Upper Denture	\$550
Geneva – Complete Lower Denture	\$550

Partial Denture – Resin Base

Simply Natural/Comfort Flex – Upper Partial	\$600
Simply Natural/Comfort Flex – Lower Partial	\$600
Geneva – Upper Partial	\$600
Geneva – Lower Partial	\$600
EstheticClasp – Upper Partial	\$600
EstheticClasp – Lower Partial	\$600
CuSil – Upper Partial	\$600
CuSil – Lower Partial	\$600
Valplast – Upper Partial	\$600

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

ADA Code	Services	When using a Participating ³ Dentist
	Valplast – Lower Partial	\$600
	Partial Denture – Cast Metal Base with Resin Saddles	
	Comfort Flex – Upper Partial	\$600
	Comfort Flex – Lower Partial	\$600
	Valplast – Upper Partial	\$600
	Valplast – Lower Partial	\$600
	Denture Relines	
	PermaSoft – Complete Upper Denture (Laboratory)	\$100
	PermaSoft – Complete Lower Denture (Laboratory)	\$100
	PermaSoft – Partial Upper Denture (Laboratory)	\$100
	PermaSoft – Partial Lower Denture (Laboratory)	\$100
	Implant services	
D6010	Surgical placement of implant body – endosteal implant	\$1,500
D6056	Prefabricated abutment – includes modifications and placement	\$450
D6058	Abutment supported porcelain/ceramic crown	\$1,055
D6059	Abutment supported porcelain fused to metal crown – high noble metal	\$1,050
D6060	Abutment supported porcelain fused to metal crown – predominately base metal	\$1,000
D6061	Abutment supported porcelain fused to metal crown – noble metal	\$1,050
D6062	Abutment supported cast metal crown – high noble metal	\$1,050
D6063	Abutment supported cast metal crown – predominately base metal	\$900
D6064	Abutment supported cast metal crown – noble metal	\$950
D6065	Implant supported porcelain/ceramic crown	\$990
D6066	Implant supported crown – porcelain fused to high noble alloys	\$970
D6067	Implant supported crown – high noble alloys	\$935
D6068	Abutment supported retainer, porcelain/ceramic FPD	\$1,055
D6069	Abutment supported retainer, metal FPD, high noble	\$1,040
D6070	Abutment supported retainer, porcelain/metal FPD, base metal	\$985
D6071	Abutment supported retainer, porcelain/metal FPD, noble	\$1,000
D6072	Abutment supported retainer, cast metal FPD, high noble	\$980
D6073	Abutment supported retainer, cast metal FPD, base metal	\$885
D6074	Abutment supported retainer, cast metal FPD, noble	\$955
D6075	Implant supported retainer for ceramic FPD	\$1,040
D6076	Implant supported retainer for porcelain/metal FPD	\$1,015
D6077	Implant supported retainer for cast metal FPD	\$935
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure. This procedure is not to be performed on the same day as D1110, D4346, or D4910.	\$25
D6085	Provisional implant crown	\$0
D6092	Re-cement or re-bond implant/abutment supported crown	\$45

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

ADA Code	Services	When using a Participating ³ Dentist
D6093	Re-cement implant/abutment supported FPD	\$65
D6094	Abutment supported crown – titanium and titanium alloys	\$640
D6194	Abutment supported retainer crown, FPD, titanium	\$640
Fixed prosthodontics		
D6210	Pontic – cast high noble metal	\$225
D6211	Pontic – cast predominantly base metal	\$75
D6212	Pontic – cast noble metal	\$175
D6214	Pontic – titanium and titanium alloys	\$225
D6240	Pontic – porcelain fused to high noble metal	\$225
D6241	Pontic – porcelain fused to predominantly base metal	\$75
D6242	Pontic – porcelain fused to noble metal	\$175
D6242	Pontic – porcelain fused to any metal for molars	Add \$75 to nonmolar copayment fee
D6245	Pontic – porcelain/ceramic	\$250
D6253	Provisional Pontic – further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary pontic for routine prosthetic fixed partial dentures.	\$15
D6600	Retainer inlay – porcelain/ceramic – two surfaces	\$195
D6601	Retainer inlay – porcelain/ceramic – three or more surfaces	\$210
D6602	Retainer inlay – cast high noble metal – two surfaces	\$225
D6603	Retainer inlay – cast high noble metal – three or more surfaces	\$275
D6604	Retainer inlay – cast predominantly base metal – two surfaces	\$125
D6605	Retainer inlay – cast predominantly base metal – three or more surfaces	\$175
D6606	Retainer inlay – cast noble metal – two surfaces	\$175
D6607	Retainer inlay – cast noble metal – three or more surfaces	\$225
D6608	Retainer onlay – porcelain/ceramic – two surfaces	\$195
D6609	Retainer onlay – porcelain/ceramic – three or more surfaces	\$210
D6610	Retainer onlay – cast high noble metal – two surfaces	\$225
D6611	Retainer onlay – cast high noble metal – three or more surfaces	\$275
D6612	Retainer onlay – cast predominantly base metal – two surfaces	\$125
D6613	Retainer onlay – cast predominantly base metal – three or more surfaces	\$175
D6614	Retainer onlay – cast noble metal – two surfaces	\$175
D6615	Retainer onlay – cast noble metal – three or more surfaces	\$225
D6624	Inlay – titanium	\$225
D6634	Onlay – titanium	\$225
D6740	Retainer crown – porcelain/ceramic	\$225
D6750	Retainer crown – porcelain fused to high noble metal	\$225
D6751	Retainer crown – porcelain fused to predominantly base metal	\$75
D6752	Retainer crown – porcelain fused to noble metal (anterior and premolar teeth only)	\$175

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

ADA Code	Services	When using a Participating ³ Dentist
D6752	Crown – porcelain fused to any metal for molars	Add \$75
D6780	Retainer crown – 3/4 cast high noble metal	\$225
D6781	Retainer crown – 3/4 cast predominantly base metal	\$75
D6782	Retainer crown – 3/4 cast noble metal	\$175
D6783	Retainer crown – 3/4 porcelain/ceramic (anterior and premolar teeth only)	\$225
D6784	Retainer crown – 3/4 titanium and titanium alloys	\$225
D6790	Retainer crown – full cast high noble metal	\$75
D6791	Retainer crown – full cast predominantly base metal	\$175
D6793	Interim retainer crown – further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary retainer crown for a routine prosthetic restoration.	\$15
D6794	Retainer crown – titanium and titanium alloys	\$225
D6930	Re-cement or re-bond fixed partial denture	\$0
D6980	Fixed partial denture repair necessitated by restorative material failure	\$50 ⁶
D6985	Pediatric partial denture – fixed, temporary	\$180
Alternative bridge materials		
Premium materials are frequently offered by dentists as alternatives to the standard porcelain/ceramic substrate and porcelain-fused-to-metal materials for dental restorations. These materials are marketed under different brand names and may be available through your Blue Shield of California Participating Provider at the copayments listed below. Crowns, bridges, inlays, and onlays, fabricated in these premium material alternatives and prepared and delivered on the same day are subject to an additional \$250.00 in-office lab fee.		
	CEREC, Full-Z, Bruxzir, Lava, PrismaTik	\$645
	CEREC Blue Block, e.Max, Procera	\$845
	Lava (layered), e.Max (layered), Procera (Layered)	\$900
Porcelain fused to high noble crown		
	Captek, Bio-2000	\$675
	Occlusal Gold, Design, Synspar	\$675
Oral surgery		
D7111	Extraction – coronal remnants – primary tooth	\$0/tooth
D7140	Extraction – erupted tooth or exposed root, including elevation and/or forceps removal	\$0/tooth
D7210	Extraction – erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	\$0
D7220	Removal of impacted tooth – soft tissue	\$0
D7230	Removal of impacted tooth – partially bony	\$0
D7240	Removal of impacted tooth – completely bony	\$0
D7241	Removal of impacted tooth – completely bony with unusual surgical complications	\$0
D7250	Removal of residual tooth roots – cutting procedure	\$0
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	\$100

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

ADA Code	Services	When using a Participating ³ Dentist
D7270	Tooth reimplantation and/or stabilization of accidentally displaced tooth	\$0
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	\$0
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	\$0
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	\$0
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	\$0
D7510	Incision and drainage of abscess – intraoral soft tissue	\$0
Orthodontics		
D8020	Limited Orthodontic treatment of the transitional dentition (up to 24 months of active treatment)	\$1,000
D8030	Limited Orthodontic treatment of the adolescent dentition (up to 24 months of active treatment)	\$1,000
D8040	Limited Orthodontic treatment of the adult dentition (up to 24 months of active treatment)	\$1,000
D8050	Interceptive Orthodontic treatment of the primary dentition (up to 24 months of active treatment)	\$1,150
D8060	Interceptive Orthodontic treatment of the transitional dentition (up to 24 months of active treatment)	\$1,150
D8070	Comprehensive Orthodontic treatment of the transitional dentition – (child through age 13)	\$1,775 ⁸
D8080	Comprehensive Orthodontic treatment of the adolescent dentition	\$1,775 ⁸
D8090	Comprehensive Orthodontic treatment of the adult dentition	\$1,975 ⁸
D8660	Pre-Orthodontic treatment examination to monitor growth and development	\$0 ⁸
D8670	Periodic Orthodontic treatment visit	\$0/visit ⁸
D8680	Orthodontic retention, including removal of appliances, construction and placement of retainer(s)	\$125/retainer ⁸
D8681	Removable Orthodontic retainer adjustment	\$0
D8695	Removal of fixed Orthodontic appliances for reasons other than completion of treatment	\$25
D8999	Orthodontic treatment plan and records(pre/post x-rays, photos, study models)	\$250
D8999	Active Orthodontic treatment beyond 24 months – per visit.	\$75
Adjunctive general services		
D9110	Palliative treatment of dental pain – per visit	\$0/visit ⁹
D9120	Fixed partial denture sectioning	\$25
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0
D9222	Deep sedation/general anesthesia – first 15 minutes	\$117
D9223	Deep sedation/general anesthesia – each subsequent 15 minutes (only for removal of impacted wisdom teeth (1,16, 17, and 32) age 17 and older)	\$85

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

ADA Code	Services	When using a Participating ³ Dentist
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide (only for removal of impacted wisdom teeth (1,16, 17, and 32) age 17 and older)	\$15
D9239	Intravenous moderate conscious sedation/anesthesia – first 15 minutes	\$100
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minutes (only for removal of impacted wisdom teeth (1, 16, 17, and 32) age 17 and older)	\$65
D9310	Consultation – diagnostic consultation provided by dentist or physician other than requesting dentist or physician (as necessary)	\$25
D9311	Consultation with a medical health care professional	\$0
D9430	Office visit for observation during regularly scheduled hours – no other services performed	\$0/visit
D9440	Office visit – after regularly scheduled hours	\$25/visit
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9630	Other drugs and/or medicaments dispensed in the office for home use	\$15
D9910	Application of desensitizing medicament	\$15
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth (not to be used under restorations)	\$15
D9930	Treatment of complication (post-surgical), unusual circumstances, by report	\$0
D9932	In office cleaning and inspection of removable complete upper denture (once every 6 months)	\$10
D9933	In office cleaning and inspection of removable complete lower denture (once every 6 months)	\$10
D9934	In office cleaning and inspection of removable partial upper denture (once every 6 months)	\$10
D9935	In office cleaning and inspection of removable partial lower denture (once every 6 months)	\$10
D9942	Repair and/or reline of occlusal guard	\$40
D9943	Occlusal guards adjustment – coverage is limited to only soft guards that are a Plan covered benefit	\$10
D9944	Occlusal guards – hard appliance, full arch	\$250
D9945	Occlusal guards – soft appliance, full arch	\$150
D9946	Occlusal guards – hard appliance, partial arch	\$200
D9951	Occlusal adjustment – limited	\$15
D9961	Duplicate/copy patient's records	\$25
D9972	External bleaching – per arch, performed in office	\$250
D9973	External bleaching – per tooth	\$25
D9975	External bleaching for home application – per arch	\$125
D9986	Missed appointment	\$25
D9987	Cancelled appointment	\$25
D9990	Certified translation or sign-language services per charge to member or provider	\$0
D9995	Teledentistry – synchronous; real-time encounter	\$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 ³ Dentist
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	\$0

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).

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 Laboratory Fees:

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.

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.

8 Orthodontic Services:

Orthodontic Covered Services. The Copayment or Coinsurance for 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.

9 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.

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 California1-800-585-8111

Outside California1-800-323-7201

PROBLEM RESOLUTION AND/OR GRIEVANCES:

In California1-800-585-8111

Outside California1-800-323-7201

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.

Timely Access to Dental Care Services

Blue Shield provides the following guidelines for timely access to care from Dental Providers:

Service	Access to Care
Urgent Care	Within 72 hours
Non-urgent care	Within 30 business days
Preventive dental care	Within 40 business days

Note: For availability of interpreter services at the time of the Member's appointment, contact customer service at the number shown in the "Dental Customer Service" section of this booklet. More information for interpreter services is located in the Notice of the Availability of Language Assistance Services section of this Evidence of Coverage.

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.

Telehealth Services

This Plan covers services appropriately delivered by any Dentist remotely via communications technologies on the same basis and to the same extent as the same in-person services.

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.

Enhanced Dental Benefits for Pregnant Women

This Plan provides additional or enhanced Benefits for women who are pregnant. When the Benefits below are available, they are not subject to the Calendar Year Deductible and the Subscriber is responsible for a lower Copayment or Coinsurance amount.

Additional Benefits for women during pregnancy include:

1. One (1) additional routine adult prophylaxis including periodontal prophylaxis for gingivitis (Note: This prophylaxis is in addition to the prophylaxis provided under Diagnostic and Preventive Services);
2. One (1) periodontal maintenance visit if warranted by a history of periodontal treatment*; and
3. One (1) course (up to four (4) quadrants) of periodontal scaling and root planing with a documented existing periodontal condition*.

*Note: If these services are required outside of pregnancy, coverage is available under the periodontics Benefits of this Plan.

Accrual balance

You can check your accrual balances toward your Calendar Year Deductible and Maximum Calendar Year Benefit at any time by logging into your member portal online, which is updated daily, or calling Customer Service at the number on the back of your ID card. Your accrual balance information is updated once a claim is received and processed and may not reflect recent services. Your accrual balances will also be included on the explanation of Benefits you receive once a claim has been processed.

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. any service, procedure, or supply which is received or expenses incurred prior to the patient's effective date of coverage;
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, 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 pericoronitis alone is not Medical Necessity;
20. 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;
21. treatment as a result of Accidental Injury, including setting of fractures or dislocation;
22. charges for second opinions, unless previously authorized by the Dental Plan Administrator;

23. 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;
24. 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;
25. 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;
26. replacement of lost, missing, stolen or damaged or prosthetic device;
27. services arising from voluntary self - inflicted injury or illness, whether the patient is sane or insane;
28. house calls for dental services;
29. training and/or appliances to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
30. 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;
31. temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
32. replacement of existing crowns, bridges or dentures that are less than five (5) years old;
33. charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
34. duplicate dentures, prosthetic devices or any other duplicate appliance;
35. 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;
36. 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. surgical Orthodontics incidental to Orthodontic treatment;
3. treatment for myofunctional therapy;
4. changes in treatment necessitated by an accident;
5. 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;
6. treatment for TMJ (temporomandibular joint) disorder or dysfunction;
7. ceramic braces which are considered to be cosmetic;
8. x-rays for Orthodontic purposes (to include full mouth screen and cephalometrics);
9. replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
10. 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;
11. 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. fluoride treatment;
 - C. bitewing x-rays (maximum four (4) per year;
 - D. tissue conditioning;
 - E. 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;
 - F. Periodontic maintenance.
2. one (1) in twelve (12) months:
 - A. denture (complete or partial) relines;
 - 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).
 - D. Extra oral-first 2D projection radiographic image crated using a stationary radiation source and detector;
 - E. Vertical bitewings 7 to 8 images;
 - F. Nutritional counseling for control of dental disease;
 - G. Tobacco counseling for the control and prevention of oral disease;
 - H. Provisional crown;
 - I. Scaling in presence of generalized moderate or severe gingival inflammation.
3. one (1) every eighteen (18) months:
 - A. Interim therapeutic restoration-primary detention;
 - B. Resin B145 C145 infiltration of incipient smooth surface lesions
4. 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.
 - F. 2D Oral/facial photographic image, non-orthodontic, obtained intraorally or extraorally.
5. 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.
6. 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 and recement;
 - K. diagnostic cast.
 - L. immediate maxillary partial dentures;
 - M. interim partial dentures;
 - N. add metal substrate to new acrylic full denture (per arch);
 - O. abutment and implant supported retainers;
 - P. labial veneers and labial veneer repairs;
 - Q. restorative foundation for indirect restoration;
 - R. inlays and onlays;
 - S. pediatric partial denture-fixed temporary.
7. once (1) per tooth per five (5) years:
 - A. Clinical crown lengthening.
8. one (1) tooth) per lifetime:
 - A. pulpal therapy and regeneration;
 - B. apexification/recalcification;
 - C. tooth reimplantation and/or stabilization of accidentally displaced tooth.
9. once (1) per lifetime:
 - A. All orthodontic procedures, transitional, interim, limited, and comprehensive;

- B. Removable orthodontic retainer adjustment.
- 10. two (2) in a consecutive twelve (12) month period:
 - A. routine prophylaxis
 - B. Interim Caries arresting medicament application – per tooth. Does not include dental varnish fluoride application.
- 11. referral to a specialty care Dentist is limited to Orthodontics, Oral Surgery, Periodontics, Prosthodontics, Endodontics and Pedodontics.
- 12. 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.
- 13. 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.
- 14. 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.
- 15. 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.
- 16. child fluoride (including fluoride varnish) – one (1) per six (6) month period through the end of the month in which the Member turns nineteen (19).
- 17. 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.
- 18. Oral Surgery services are limited to removal of teeth, bony protuberances and frenectomy.
- 19. 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.
- 20. 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;
- 21. General or IV sedation is not a covered benefit for dental phobic reasons.
- 22. 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.
- 23. restorations, crowns, inlays and onlays - covered only if necessary to treat diseased or accidentally fractured teeth.
- 24. root canal treatment – one (1) per tooth per lifetime.
- 25. root canal retreatment – one (1) per tooth per lifetime.
- 26. pulpal therapy – through age five (5) on primary anterior teeth and through age eleven (11) on primary posterior teeth.
- 27. for mucogingival surgeries, one site is equal to two consecutive teeth or bounded spaces.
- 28. 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.
- 29. 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;

30. 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 110 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 30-day grace period. Your Employer will be liable for all Dues accrued while this Plan continues in force including those accrued during the 30-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
P.O. Box 272540
Chico, CA 95927-2540

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
Attn: Dental Appeals/Grievances
P.O. Box 30545
Salt Lake City, UT 84130-0545

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

California 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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's internet website, (**www.dmhca.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 30 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

Notice about Confidential Communication Requests

A health plan shall notify Subscribers and enrollees that they may request a confidential communication pursuant to the following and how to make the request.

A health plan shall permit Subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations.

A health plan may require the Subscriber or enrollee to make a request for a confidential communication in writing or by electronic transmission.

The confidential communication request shall be valid until the Subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.

The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication.

A confidential communication request may be submitted in writing to Blue Shield of California at the mailing address, email address, or fax number at the bottom of this page. A confidential communication form, available by going to blueshieldca.com/privacy and clicking on "privacy forms," may be used when submitting a confidential communication request in writing, but it is not required.

Once in place, a valid confidential communication request prevents Blue Shield from: 1. Requiring the protected individual to obtain the primary Subscriber's or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care; and 2.

Disclosing medical information relating to sensitive health services provided to a protected individual to the primary Subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

You may return this completed and signed form via any of these options:

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

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

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. The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this Plan. If permitted by your Employer, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however, the partnership may not be rec-

ognized by the State for other purposes as the partners do not meet the definition of “Domestic Partner” established under Section 297 of 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

Notice of privacy practices

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

This notice describes how medical information about you, as a Blue Shield member, may be used and disclosed, and how you can get access to your information.

Our privacy commitment

At Blue Shield, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously.

In the normal course of doing business, we create records about you, your medical treatment, and the services we provide to you. The information in those records is called protected health information (PHI) and includes your individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We are required by federal and state law to provide you with this notice of our legal duties and privacy practices as they relate to your PHI. We are required to maintain the privacy of your PHI and to notify you in the event that you are affected by a breach of unsecured PHI. When we use or give out ("disclose") your PHI, we are bound by the terms of this notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI.

How we protect your privacy

We maintain physical, technical, and administrative safeguards to ensure the privacy of your PHI. To protect your privacy, only Blue Shield workforce members who are authorized and trained are given access to our paper and electronic records and to non-public areas where this information is stored.

Workforce members are trained on topics including:

- Privacy and data protection policies and procedures, including how paper and electronic records are labeled, stored, filed, and accessed.
- Physical, technical, and administrative safeguards in place to maintain the privacy and security of your PHI.

Our corporate Privacy Office monitors how we follow our privacy policies and procedures, and educates our organization on this important topic.

How we use and disclose your PHI

Uses of PHI without your authorization. We may disclose your PHI without your written authorization, if necessary, while providing health benefits and services to you. We may disclose your PHI for the following purposes:

- **Treatment:**
 - To share with nurses, doctors, pharmacists, optometrists, health educators, and other healthcare professionals so they can determine your plan of care.
 - To help you obtain services and treatment you may need – for example, ordering lab tests and using the results.
 - To coordinate your health care and related services with a healthcare facility or professional.

- **Payment:**

- To obtain payment of premiums for your coverage.
- To make coverage determinations – for example, to speak to a healthcare professional about payment for services provided to you.
- To coordinate benefits with other coverage you may have – for example, to speak to another health plan or insurer to determine your eligibility or coverage.
- To obtain payment from a third party that may be responsible for payment, such as a family member.
- To otherwise determine and fulfill our responsibility to provide your health benefits – for example, to administer claims.

- **Healthcare operations:**

- To provide customer service.
- To support and/or improve the programs or services we offer you.
- To assist you in managing your health – for example, to provide you with information about treatment alternatives you may be entitled to, or to provide you with healthcare service or treatment reminders.
- To support another health plan, insurer, or healthcare professional who has a relationship with you, to improve the programs it offers you – for example, for case management or in support of an accountable care organization (ACO) or patient-centered medical home arrangement.
- For underwriting, dues, or premium rating, or other activities relating to the creation, renewal, or replacement of a contract for health coverage or insurance. Please note, however, that we will not use or disclose your PHI that is genetic information for underwriting purposes – doing so is prohibited by federal law.

We may also disclose your PHI without your written authorization for other purposes, as permitted or required by law. This includes:

- **Disclosures to others involved in your health care.**

- If you are present or otherwise available to direct us to do so, we may disclose your PHI to others, for example, a family member, a close friend, or your caregiver.
- If you are in an emergency situation, are not present, are incapacitated, or if you are deceased, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interest. If we do disclose your PHI in a situation where you are unavailable, we will disclose only information that is directly relevant to the person's involvement with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, your general medical condition, or your death.
- We may disclose your minor child's PHI to the child's other parent.

- **Disclosures to your plan sponsor.** We may disclose PHI to the sponsor of your group health plan, which may be your employer, or to a company acting on behalf of the plan sponsor, so that they can monitor, audit, and otherwise administer the health plan you participate in. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your plan sponsor's plan documents for information about whether your employer/plan sponsor receives PHI, and for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI.

- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:
 - Companies that perform certain services on behalf of Blue Shield. For example, we may engage vendors to help us provide information and guidance to members with chronic conditions like diabetes and asthma.
 - Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.
 - **Communications.** We may use your PHI to contact you with information about your Blue Shield health plan coverage, benefits, health-related programs and services, treatment reminders, or treatment alternatives available to you. We do not use your PHI for fundraising purposes.
 - **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of the general public.
 - **Public health activities.** We may disclose your PHI to:
 - Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations.
 - Report child abuse or neglect, or adult abuse, including domestic violence, to a government authority authorized by law to receive such reports.
 - Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety, or effectiveness of the product or activity.
 - Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give such a notice.
 - **Health oversight activities.** We may disclose your PHI to:
 - A government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid.
 - Other regulatory programs that need health information to determine compliance.
 - **Research.** We may disclose your PHI for research purposes, but only according to, and as allowed by, law.
 - **Compliance with the law.** We may use and disclose your PHI to comply with the law.
 - **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
 - **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
 - **Government functions.** We may disclose your PHI to various departments of the government, such as the U.S. military or the U.S. Department of State, as required by law.
 - **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws.
- Uses of PHI that require your authorization.** Other than for the purposes described above, we must obtain your written authorization to use or disclose your PHI. For example, we will not use your PHI for marketing purposes without your prior written authorization, nor will we give your PHI to a prospective employer without your written authorization.

Uses and disclosure of certain PHI deemed “highly confidential.” For certain kinds of PHI, federal and state law may require enhanced privacy protection. This includes PHI that is:

- Maintained in psychotherapy notes.
- About alcohol and drug abuse prevention, treatment, and referral.
- About HIV/AIDS testing, diagnosis, or treatment.
- About venereal and/or communicable disease(s).
- About genetic testing.

We can only disclose this type of specially protected PHI with your prior written authorization except when specifically permitted or required by law.

Authorization cancellation. At any time, you may cancel a written authorization that you previously gave us. When submitted to us in writing, the cancellation will apply to future uses and disclosures of your PHI. It will not affect uses or disclosures made previously, while your authorization was in effect.

Your individual rights

You have the following rights regarding the PHI that Blue Shield creates, obtains, and/or maintains about you:

- **Right to request restrictions.** You may ask us to restrict the way we use and disclose your PHI for treatment, payment, and healthcare operations, as explained in this notice. We are not required to agree to your restriction requests, but we will consider them carefully.

If we agree to a restriction request, we will abide by it until you request or agree to terminate the restriction. We may also inform you that we are terminating our agreement to a restriction. In that case, the termination will apply only to PHI created or received after we have informed you of the termination.

- **Right to receive confidential communications.** You may ask to receive Blue Shield communications containing PHI by alternative means or at alternative locations. As required by law, and whenever feasible, we will accommodate reasonable requests. We may require that you make your request in writing. If your request involves a minor child, we may ask you to provide legal documentation to support your request.
- **Right to access your PHI.** You may ask to inspect or to receive a copy of certain PHI that we maintain about you in a “designated record set.” This includes, for example, records of enrollment, payment, claims adjudication, and case or medical management record systems, and any information we used to make decisions about you. Your request must be in writing. Whenever possible, and as required by law, we will provide you with a copy of your PHI in the form (paper or electronic) and format you request. If you request a copy of your PHI, we may charge you a reasonable, cost-based fee for preparing, copying, and/or mailing it to you. In certain limited circumstances permitted by law, we may deny you access to a portion of your records.
- **Right to amend your records.** You have the right to ask us to correct or amend the PHI that we maintain about you in a designated record set. Your request must be made in writing and explain why you want your PHI amended. If we determine that the PHI is inaccurate or incomplete, we will correct it if permitted by law. If a doctor or healthcare facility created the PHI that you want to change, you should ask them to amend the information.

- **Right to receive an accounting of disclosures.**

Upon your written request, we will provide you with a list of the disclosures we have made of your PHI for a specified time period, up to six years prior to the date of your request. However, the list will exclude:

- Disclosures you have authorized.
- Disclosures made earlier than six years before the date of your request.
- Disclosures made for treatment, payment, and healthcare operations purposes, except when required by law.
- Certain other disclosures that we are allowed by law to exclude from the accounting.

If you request an accounting more than once during any 12-month period, we will charge you a reasonable, cost-based fee for each accounting report after the first one.

- **Right to name a personal representative.**

You may name another person to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the healthcare professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make healthcare decisions for you.

- **Right to receive a paper copy of this notice.**

Upon your request, we will provide a paper copy of this notice, even if you have agreed to receive the notice electronically. See the "Notice Availability and Duration" section of this notice.

Actions you may take

Contact Blue Shield. If you have questions about your privacy rights, believe that we may have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact us:

Blue Shield of California Privacy Office

P.O. Box 272540

Chico, CA 95927-2540

Phone: **(888) 266-8080** (toll-free)

Fax: **(800) 201-9020** (toll-free)

Email: **privacy@blueshieldca.com**

For certain types of requests, you must complete and mail us a form that is available either by calling the customer service number on your Blue Shield member ID card or by visiting our website at **blueshieldca.com/privacyforms**.

Contact a government agency. You may also file a written complaint with the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe we may have violated your privacy rights. Your complaint may be sent by email, fax, or mail to the HHS Office for Civil Rights (OCR).

For more information, or to file a complaint with the Secretary of HHS, visit the OCR website at **www.hhs.gov/ocr/privacy/hipaa/complaints**.

If you are a California resident, you may contact the OCR Regional Manager for California as follows:

Region IX Regional Manager

Office for Civil Rights

U.S. Department of Health & Human Services

90 7th St., Suite 4-100

San Francisco, CA 94103

Phone: (800) 368-1019

Fax: (202) 619-3818

TTY: (800) 537-7697

We will not take any action against you if you exercise your right to file a complaint, either with us or with HHS.

Notice availability and duration

Notice availability. A copy of this notice is available by calling the customer service number on your Blue Shield member ID card or by visiting our website at blueshieldca.com/privacynotice.

Right to change terms of this notice. We are required to abide by the terms of this notice as long as it remains in effect. We may change the terms of this notice at any time, and, at our discretion, we may make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new notice.

If we change this notice, we will update the notice on our website, and if you are enrolled in a Blue Shield benefit plan at that time, we will send you the new notice when and as required by law.

Effective date. This notice is effective as of August 16, 2013.

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 cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Blue Shield of California 遵循適用的州法律和聯邦公民權利法律, 並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡或殘障為由而進行歧視。

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: blueshieldca.com/notices. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en blueshieldca.com/notices. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 blueshieldca.com/notices。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。

