Disclosure

Family Dental Plan Disclosure Form

Blue Shield Disclosure Form:

Family Dental PPO and Family Dental HMO Plans

This Disclosure Form is only a summary of your dental Plan. Evidence of Coverage and Health Service Agreement (Agreement) should be consulted to determine the terms and conditions governing your coverage. Blue Shield will furnish a copy of the Agreement upon request. It is your right to view the Agreement prior to enrollment in the dental Plan.

To obtain a copy of the Agreement or if you have questions about the Benefits of the Plan, please contact the Dental Customer Service Department at 1-888-271-4880.

Please read this Disclosure Form carefully and completely so that you understand which services are covered Dental Care Services, and the limitations and exclusions that apply to the Plan.

A Summary of Benefits, summarizing key elements of the Blue Shield of California Group Dental Plan you are being offered, is provided with this Disclosure Form to assist you in comparing dental plans available to you.

IMPORTANT

If you opt to receive dental services that are not Covered Services under this Plan, a Participating Dentist 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 1-877-885-0254 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Disclosure document.

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Blue Shield of California's dental plans are administered by a Dental Plan Administrator (DPA). PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR DENTAL CARE MAY BE OBTAINED.

Choice of Dentists

This Plan has separate Benefits for Pediatric Members and Adult Members. Pediatric dental Benefits are available for Members through the end of the month in which the Member turns 19. Adult dental Benefits are available for ages 19 and older.

This dental Plan is offered through Covered California. For more information about Covered California, please visit www.coveredca.com or call 1-888-975-1142. If you have any questions regarding the information in this booklet, need assistance, or have any problems, you may contact your Dental Plan Member Services Department at: 1-877-885-0254.

DHMO Plans: 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 Participating Dentist at the time of enrollment. This decision is an important one because your Participating Dentist 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 Participating Dentist 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 Participating Dentist must also be selected for a newborn or child placed for adoption.

If you do not select a Participating Dentist 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 Participating Dentist for you and your Dependents, and notify you of the designated Participating Dentist. This designation will remain in effect until you advise the Plan of your selection of a different Participating Dentist.

DPPO Plans: With Blue Shield of California's (Blue Shield's) dental plans, you receive a greater Benefit when using Participating Dentists.

Participating Dentists agree to accept a Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Coinsurance amount, as payment in full for Covered Services. This is not true of Non-Participating Dentists.

In some instances, the Non-Participating Dentist's Allowable Amount may be higher than the Allowable Amount for a Participating Dentist; however, if you go to a Non-Participating Dentist, your reimbursement for a service by that Non-Participating Dentist may be less than the amount billed. The Subscriber is responsible for all differences between the amount you are reimbursed and the amount billed by Non-Participating Dentists. It is therefore to your advantage to obtain dental services from Participating Dentists.

Participating Dentists submit claims for payment after their services have been rendered. These payments go directly to the Participating Dentist. You or your Non-Participating Dentist also submit claims for payment after services have been rendered. If you receive services from Non-Participating Dentist, you have the option of having payments sent directly to the Non-Participating Dentist or sent directly to you. A Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

A list of Participating Dentists located in your area can be obtained by contacting a Dental Plan Administrator at 1-877-885-0254. You may also access a list of Participating Dentists at http://www.blueshieldca.com.

Liability of Subscriber or Enrollee for Payment

DHMO Plans: You are responsible for assuring that the Dentist you choose is a Participating Dentist. A Participating Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dentist; in case there have been changes to the list of Participating Dentists.

DPPO Plans: You are responsible for assuring that the Dentist you choose is a Participating Dentist. Note: A Participating Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dentist, in case there have been changes to the list of Participating Dentists. A list of Participating Dentists located in your area can be obtained by contacting a Dental Plan Administrator at 1-877-885-0254. You may also access a list of Participating Dentists http://www.blueshieldca.com.

Facilities (Participating Dentists)

DHMO Plans: Directories of Participating Dentists are available at http://www.blueshieldca.com or by calling 1-877-885-0254.

DPPO Plans: The names of Participating Dentists in your area may be obtained by contacting a Dental Plan

Administrator at 1-877-885-0254. You may also access a list of Participating Dentists at http://www.blueshieldca.com.

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 network of Participating Dentists. Contact Customer Service 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.

Financial Responsibility for Continuity of Care Services

If a Member is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for services rendered under the Continuity of Care provision shall be no greater than for the same services rendered by a Participating Dentist in the same geographic area.

Utilization Review

DPPO Plans: State law requires that health Plans disclose to Subscribers and health Plan providers the process used to authorize or deny services under the Plan.

Blue Shield of California has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code.

To request a copy of the document describing this Utilization Review process, call the Customer Service Department at 1-888-256-3650.

Principal Benefits and Coverages

The Benefits of the Plan are listed in the Summary of Benefits. Blue Shield payments for these services, if applicable, are also listed in the Summary of Benefits.

Limitations and Exclusions

For all Blue Shield family dental plans.

The following is a summary of services and supplies not covered by Blue Shield dental plans. For a complete list of dental coverage exclusions and limitations, please refer to the Agreement for your dental plan.

DHMO Adult and Pediatric General Exclusions

Unless otherwise specifically mentioned elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Services of Dentists or other practitioners of healing arts not associated with the Dental Service Plan, except upon referral arranged by a Dental Provider and authorized by the Plan or when required in a covered emergency;
2. Any dental services received or costs that were incurred in connection with any dental procedures started prior to Member's effective date of coverage. For the purpose of this exclusion, the date on which a procedure shall be considered to have started is defined as follows:

a) For full dentures or partial dentures: on the date the final impression is taken,

b) For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared,

c) For root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex,

d) For periodontal surgery: on the date the surgery is actually performed,

e) For all other services: on the date the service is performed.

This exclusion does not apply to Covered Services to treat complications arising from services received prior to Member's effective date of coverage;

3. Dental services in excess of the limits specified in the Limitations section of the Evidence of Coverage or on the Dental Schedule and Limitations Table;
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. Cosmetic procedures including, but not limited to, bleaching, veneer facings, porcelain on molar

crowns, personalization or characterization of crowns, bridges and/or dentures;

7. Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;
8. Congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as Orthognathic surgery, including Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging;
9. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
10. 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;
11. Treatment for which payment is made by any governmental agency, including any foreign government;
12. 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 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.

13. Precious metals (if used, will be charged to the patient at the Dentist's cost);
14. Charges for second opinions, unless previously authorized by a Dental Plan Administrator;
15. Services provided to Members by out-of-network Dentists unless preauthorized by the company, except when immediate dental treatment is required as a result of a dental emergency;
16. 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;
17. Replacement of lost, missing, stolen or damaged or prosthetic device;
18. House calls for dental services;
19. All prescription and non-prescription drugs;
20. Any dental services received subsequent to the time the Member's coverage ends;
21. Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
22. Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member; and
23. Dental Care Services administered by a Pediatric Dentist, except when:

    a) The Member child's primary Dental Provider is a pediatric Dentist; or

    b) The Member child is referred to a pediatric Dentist by the primary Dental Provider.

DPPO Adult and Pediatric General Exclusions

Unless exceptions to the following general exclusions are specifically made elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Charges for services in connection with any treatment to the gums for tumors, cysts and neoplasms;
2. Dental services in excess of the limits specified in the Limitations section of the Evidence of Coverage or on the Dental Schedule and Limitations Table;
3. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers compensation law, occupational disease law or similar

legislation. However, if a contracted Dental Plan Administrator or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by a contracted Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;

4. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
5. Cosmetic dental care;
6. Hospital charges of any kind;
7. Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;
8. Treatment for which payment is made by any governmental agency, including any foreign government;
9. Charges for second opinions, unless previously authorized by the DPA;
10. 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;
11. Services provided by an individual or entity that is not licensed or certified by the state to provide Dental Care Services or is not operating within the scope of such license or certification, except as specifically stated herein;
12. Any procedure not performed in a dental office setting; except for general anesthesia when Medically Necessary;
13. General anesthesia including intravenous and inhalation sedation, except when Medically Necessary.

    General anesthesia is considered Medically Necessary when its use is:

    a) In accordance with generally accepted professional standards; and

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

    c) Due to the existence of a specific medical condition.

    Patient apprehension or patient anxiety will not constitute Medical Necessity.

    A contracted Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Medical Necessity;

14. Loss or theft of dentures or bridgework;
15. Services of dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Dental Provider and authorized by the Plan, or when required in a covered emergency;
16. Any dental services received or costs that were incurred in connection with any dental procedures started prior to Member's effective date of coverage. For the purpose of this exclusion, the date on which a procedure shall be considered to have started is defined as follows:

    a) For full dentures or partial dentures: on the date the final impression is taken,

    b) For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared,

    c) For root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex,

    d) For periodontal surgery: on the date the surgery is actually performed,

    e) For all other services: on the date the service is performed.

    This exclusion does not apply to Covered Services to treat complications arising from services received prior to Member's effective date of coverage;

17. Any dental services received subsequent to the time the Member's coverage ends;
18. Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
19. Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member;
20. All prescription and non-prescription drugs;
21. The cost of precious metals used in any form of dental Benefits;
22. Dental Care Services administered by a Pediatric Dentist, except when:

    a) The Member child's primary Dental Provider is a pediatric Dentist; or

    b) The Member child is referred to a pediatric Dentist by the primary Dental Provider; and

23. House calls for dental services.

DHMO Adult General Exclusions

Unless otherwise specifically mentioned elsewhere under this Plan, this Plan does not provide Adult Benefits with respect to:

1. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a Dental Plan Administrator and its dental consultants;
2. Reimbursement to the Member or another dental office for the cost of services secured from Dentists, other than the Dental Provider or other Participating Dentist, except:
    a. When such reimbursement is expressly authorized by the Plan; or
    b. As cited under the Emergency Services and Emergency Claims provisions;
3. 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;
4. 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 Medically Necessary;
5. 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;
6. Bone grafting done for socket preservation after tooth extraction or in preparation for Implants;
7. Dental Implants (surgical insertion and/or removal), transplants, ridge augmentations, or socket preservation, and any appliance and/or crowns attached to Implants;
8. Services of prosthodontists;
9. Services of orthodontists;
10. 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;
11. Services arising from voluntary self-inflicted injury whether the patient is sane or insane;
12. Training and/or appliances to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
13. 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;
14. Temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
15. Replacement of existing crown, bridges, or dentures that are less than five (5) years old;
16. Charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
17. Duplicate dentures, prosthetic devices or any other duplicate appliance; and
18. 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.

DPPO Adult General Exclusions

Unless exceptions to the following Adult general exclusions are specifically made elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, 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;
2. Congenital mouth malformations or skeletal imbalances, including treatment required as the result of Orthognathic surgery, Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by

supernumerary teeth; and anodontia (congenitally missing teeth);

3. 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;
4. 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;
5. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been either lost or stolen within five (5) years of its installation;
6. Myofunctional therapy; biofeedback procedures; athletic mouth-guards; precision or semi-precision attachments; denture duplication; treatment of jaw fractures;
7. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw; charges for services in connection with orthodontia;
8. Charges for services in connection with orthodontia;
9. Alloplastic bone grafting materials;
10. Bone grafting done for socket preservation after tooth extraction (unless your Plan provides special Implant Benefits. Please see the Summary of Benefits to determine if you have Implant Benefits.);
11. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
12. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
13. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;
14. Services for which the Member is not legally obligated to pay, or for services for which no charge is made;
15. Treatment as a result of Accidental Injury including setting of fractures or dislocation; Treatment for which payment is made by any governmental agency, including any foreign government;
16. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
17. Charges for onlays or crowns installed as multiple abutments;
18. Any inlay restoration;
19. Charges for dental appointments which are not kept, except as specified under the Summary of Benefits;
20. Charges for services incident to any intentionally self-inflicted injury;
21. Removal of 3rd molar (wisdom) teeth other than for Medical Necessity. Medical Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not Medically Necessary;
22. 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;
23. For services provided by an individual or entity that is not licensed or certified by the state to provide Dental Care Services, or is not operating within the scope of such license or certification, except as specifically stated herein;
24. Charges for saliva and bacterial testing when caries management procedures D0601, D0602, and D0603 are performed; and
25. Any and all Implant services that have not received prior authorization and approval by a contracted Dental Plan Administrator if your Plan provides special Implant Benefits. 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.

DHMO Adult General Limitations

The following services, if listed on the Summary of Benefits or on the Dental Schedule and Limitations Table, will be subject to limitations as set forth below:

1. Referral to a specialty care Dentist is limited to Oral Surgery, Periodontics, Endodontics and pediatrics;
2. Oral Surgery services are limited to removal of teeth, bony protuberances and frenectomy.
3. 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 three (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.
4. General or IV sedation is covered for:

a) Three (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.

5. General or IV sedation is not a covered Benefit for dental-phobic reasons;
6. Restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth;
7. For mucogingival surgeries, one (1) site is equal to two (2) consecutive teeth or bounded spaces;and
8. 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.

DPPO Adult General Limitations

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

1. Oral Surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy and crown lengthening;
2. 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 three (3) teeth missing in one (1) 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;
3. General or IV sedation is not a covered Benefit for dental phobic reasons;
4. Restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth;
5. For mucogingival surgeries, one (1) site is equal to two (2) consecutive teeth or bonded spaces;
6. 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; and
7. You must be twenty-one (21) years 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 (3) 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.

Pediatric Preventive Exclusions and Limitations (D1000-D1999)

1. Fluoride treatment (D1206 and D1208) is a Benefit only for prescription strength fluoride products;
2. Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride; and
3. The application of fluoride is only a Benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.

Pediatric Restorative Exclusions and Limitations (D2000-D2999)

1. Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
2. Restorative services when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
3. Restorations for primary teeth near exfoliation;
4. Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription;
5. Prefabricated crowns for primary teeth near exfoliation;
6. Prefabricated crowns are not a Benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214);
7. Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
8. Prefabricated crowns are not a Benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;

9. Prefabricated crowns are not a Benefit when a tooth can be restored with an amalgam or resin-based composite restoration;
10. Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
11. Laboratory crowns are not a Benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; and
12. Laboratory processed crowns are not a Benefit when the tooth can be restored with an amalgam or resin-based composite.

Pediatric Endodontic Exclusions and Limitations (D3000-D3999)

1. Endodontic procedures when the prognosis of the tooth is questionable due to non- restorability or periodontal involvement;
2. Endodontic procedures when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch; and
3. Endodontic procedures for third molars, unless the third molar occupies the first or second molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

Pediatric Periodontal Exclusions and Limitations (D4000-D4999)

1. Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.

Pediatric Prosthodontic (Removable) Exclusions and Limitations (D5000-D5899)

1. Prosthodontic services provided solely for cosmetic purposes;
2. Temporary or interim dentures to be used while a permanent denture is being constructed;
3. Spare or backup dentures;
4. Evaluation of a denture on a maintenance basis;
5. Preventative, endodontic or restorative procedures are not a Benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a Benefit;
6. Partial dentures are not a Benefit to replace missing 3rd molars;
7. Laboratory relines (D5760 and D5761) are not a Benefit for resin based partial dentures (D5211and D5212);
8. Laboratory relines (D5750, D5751, D5760 and D5761) are not a Benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741);
9. Chairside relines (D5730, D5731, D5740 and D5741) are not a Benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761);
10. Tissue conditioning (D5850 and D5851) is only a Benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment; and
11. Tissue conditioning (D5850 and D5851) is a Benefit the same date of service as an immediate prosthesis that required extractions.

Pediatric Implant Exclusions and Limitations (D6000-D6199)

1. Implant services are a Benefit only when exceptional medical conditions are documented and the services are considered Medically Necessary; and
2. Single tooth implants are not a Benefit.

Pediatric Prosthodontic (Fixed) Exclusions and Limitations (D6200-D6999)

1. Fixed partial dentures (bridgework) are not a Benefit; however, the fabrication of a fixed partial denture shall be considered when medical conditions or employment preclude the use of a removable partial denture;
2. Fixed partial dentures are not a Benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement;
3. Posterior fixed partial dentures are not a Benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the Member's masticatory ability;
4. Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634); and
5. Cast resin bonded fixed partial dentures (Maryland Bridges).

Pediatric Oral and Maxillofacial Surgery Exclusions and Limitations (D7000-D7999)

1. The prophylactic extraction of 3rd molars is not a Benefit;
2. TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a Benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation;

3. TMJ dysfunction procedures solely for the treatment of bruxism is not a Benefit; and

4. Suture procedures (D7910, D7911 and D7912) are not a Benefit for the closure of surgical incisions.

Pediatric Orthodontic Exclusions and Limitations

Orthodontic procedures are covered when Medically Necessary to treat handicapping malocclusion, cleft palate, or facial growth management cases for Members under the age of 19, when prior authorization is obtained.

Medically Necessary orthodontic treatment is limited to the following instances related to an identifiable medical condition. Initial orthodontic examination (D0140) called the Limited Oral Evaluation must be conducted. This examination includes completion and submission of the completed HLD Score Sheet with the Specialty Referral Request Form. The HLD Score Sheet is the preliminary measurement tool used in determining if the Member qualifies for Medically Necessary orthodontic services.

Orthodontic procedures are a Benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

Those immediate qualifying conditions are:

1. Cleft lip and or palate deformities.

2. Craniofacial Anomalies including the following:

   - Crouzon's syndrome,
   - Treacher-Collins syndrome,
   - Pierre-Robin syndrome,
   - Hemi-facial atrophy, Hemfacial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.

3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).

4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a Benefit of the program.

5. Severe traumatic deviation must be justified by attaching a description of the condition.

6. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

   The remaining conditions must score 26 or more to qualify (based on the HDL Index).

Excluded are the following conditions:

- Crowded dentitions (crooked teeth)
- Excessive spacing between teeth
- Temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies
- Treatment in progress prior to the effective date of this coverage.
- Extractions required for orthodontic purposes
- Surgical orthodontics or jaw repositioning
- Myofunctional therapy
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan or for changes in Orthodontic treatment necessitated by any kind of accident
- Palatal expansion appliances
- Services performed by outside laboratories
- Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

Premiums

Monthly Premiums are stated in the Appendix attached to your Agreement. Blue Shield of California offers a variety of options and methods by which you may pay your Premiums.

Please call Customer Service at 1-877-885-0254 to discuss these options or visit http://www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield of California
P. O. Box 60514
City of Industry, CA 91716

Changes to Premiums

Blue Shield may change your Premium as the law permits. Blue Shield can change your Premium if:

1. A federal, state, or other taxing or licensing authority imposes a tax or fee;
2. Blue Shield's federal income tax associated with federal excise tax increases;
3. Federal or state law requires it; or
4. You relocate to a different geographic rating region.

Premiums may vary due to differences in the cost of health care services within each geographic rating region.

Blue Shield will give the Subscriber written notice at least 10 days before the open enrollment period each year, or 60 days prior to plan renewal, of any Premium change.

Your Premiums may change without written notice when:

You move to a new geographic rating region. Your new Premium is effective the first of the month after your last billing cycle.

You add or drop a Dependent. For more information about changing Dependents, see the Enrollment and effective dates of coverage section.

Other Charges

Calendar Year Deductible

For dental Plans with a Calendar Year Deductible, the Deductible applies to all Covered Services and supplies furnished by Participating and Non-Participating Dentists, except as specified in the Summary of Benefits. It is the amount which you must pay out of pocket for charges that would otherwise be payable for Dental Care Services and supplies. Charges in excess of the Allowable Amount do not apply toward the Deductible. This per Member Deductible applies separately to each covered Member each Calendar Year. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan.

The Calendar Year per Member is listed in the Summary of Benefits which is attached to and made a part of this Disclosure Form.

Payment and Subscriber Coinsurance Amount Responsibilities

After any applicable Deductible has been satisfied, payments will be provided based on the Allowable Amount determined by a Dental Plan Administrator, to Participating and Non-Participating Dentists for the Benefits of this Plan, subject to the Coinsurance amount percentages and Benefit maximums indicated below.

For dental plans with a calendar year maximum payment, the maximum per Member, per Calendar Year amount payable by Blue Shield for Covered Services and supplies provided by any combination of Participating and Non-Participating Dentists is listed in the Summary of Benefits which is attached to and made a part of this Disclosure Form.

*NOTE: If your Plan provides Benefits for orthodontia, a separate Benefit maximum applies to Orthodontic services. See the Summary of Benefits which is attached to and made a part of this Disclosure Form.

Out-Of-Pocket Maximum

For dental Plans with an Out-of-Pocket Maximum, the out-of-pocket maximum per Member for all Covered Services and supplies furnished by Participating and Non-Participating Dentists is specified on the Summary of Benefits. This amount is the most the Member pays during the coverage period (usually one year) for the Member's share of the cost of Covered Services. This limit helps the Member plan for dental care expenses.

Reimbursement Provisions

Procedure for Filing a Claim

Claims for covered dental services should be submitted on a dental claim form which may be obtained from the Dental Plan Administrator, at http://www.blueshieldca.com or any Blue Shield of California office. Have your Dentist complete the form and mail it to the Dental Plan Administrator Service Center shown on the last page of this booklet.

The Dental Plan Administrator will provide payments in accordance with the provisions of the Agreement. You will receive an explanation of Benefits after the claim has been processed.

All claims for reimbursement must be submitted to the Dental Plan Administrator within one year after the month in which the service is rendered. The Dental Plan Administrator will notify you of its determination within 30 days after the receipt of the claim.

Renewal Provisions

This Agreement shall be renewed upon receipt of pre-paid Premiums. Renewal is subject to Blue Shield of California's right to amend this Agreement. Any change in Dues or Benefits, including but not limited to Covered Services, Deductible, Copayment, Coinsurance and annual Copayment maximum amounts, are effective after 60 days' notice to the Subscriber's address of record with Blue Shield of California.

Entire Agreement: Changes

This Agreement, including the appendices, attachments, or other documents incorporated by reference, constitutes the entire Agreement. Any statement made by a Member shall, in the absence of fraud, be deemed a representation and not a warranty. No changes in this Agreement shall be valid unless approved by a corporate officer of Blue Shield of California and a written endorsement issued. No representative has authority to change this Agreement or to waive any of its provisions.

Benefits, such as Covered Services, Calendar Year Benefits, Deductible, Copayment, or Maximum per Member and family Copayment/Coinsurance responsibility amounts are subject to change as permitted by law. Blue Shield will give the Subscriber written notice of Premiums rates or coverage

changes, unless otherwise specified in the Agreement. We will send this notice at least 60 days prior to plan renewal.

Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain Benefits.

When coverage ends

Your coverage will end if:

1. The Subscriber cancels or does not renew coverage;
2. Blue Shield or Covered California cancels or does not renew coverage; or
3. Blue Shield or Covered California rescinds coverage.

If the Subscriber pays Premiums beyond the date coverage ends, those Premiums are unearned. Blue Shield will refund unearned Premiums to the Subscriber, minus any amount Blue Shield pays for Benefits received after the date coverage ends. Blue Shield will only issue a refund to the Subscriber if the amount the Subscriber paid in unearned Premiums is more than the amount Blue Shield pays for Benefits after coverage ends.

When Pediatric Coverage Ends

Pediatric Members of this Plan will receive the Pediatric dental Benefits through the end of the month in which the Member turns 19. Upon reaching age 19, unless we receive notice to cancel, the covered Pediatric Member will receive Benefits under the Adult dental Benefits of this Plan until coverage ends.

If the Subscriber cancels or does not renew coverage

The Subscriber can cancel coverage by giving Covered California 14 days' notice. Coverage will end at 11:59 p.m. Pacific Time on the effective date of termination.

If the Subscriber decides to cancel coverage, the actual date coverage ends is based on when the Subscriber gives notice to Covered California. Once the Subscriber's coverage is terminated, coverage under this plan cannot be reinstated. However, you may reapply for coverage during open enrollment, or if you qualify for special enrollment.

When coverage ends if the Subscriber cancels or does not renew	
If the Subscriber gives	***Date coverage ends***
14 days' notice or more	The date the Subscriber selects
Less than 14 days' notice	A date Covered California selects that is at least 14 days after receipt of your notice

If Blue Shield or Covered California cancels or does not renew coverage

Blue Shield or Covered California can cancel coverage or deny renewal, as the law permits. If this happens, the date coverage ends depends on the reason for cancellation or non-renewal.

Cancellation for Subscriber's nonpayment of Premiums

Blue Shield can cancel your coverage if the Subscriber does not pay the required Premiums in full and on time. The Subscriber is responsible for all Premiums during the term of coverage, including the grace period. If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send the Notice of Termination to the Subscriber within five business days of the cancellation. This notice will state:

1. That the Agreement has been canceled;
2. The reasons for cancellation; and
3. The specific date and time when your coverage will end.

Cancellation for fraud or intentional misrepresentation of material fact

Blue Shield or Covered California may cancel your coverage for fraud or intentional misrepresentation of material fact if you:

1. Intentionally provide false or misleading information to Blue Shield or Covered California on the enrollment application or otherwise. This includes incorrect or incomplete material information such as failing to provide Blue Shield with required or requested information in a timely manner;
2. Let someone else use your ID card to receive services; or
3. Receive, or attempt to receive, services by means of false, materially misleading, or fraudulent information, acts, or omissions.

Blue Shield or Covered California rescinds coverage

IF THE SUBSCRIBER OR ANY ENROLLED DEPENDENT COMMITS FRAUD OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT DURING THE APPLICATION PROCESS, BLUE SHIELD OR COVERED CALIFORNIA CAN

RETROACTIVELY CANCEL COVERAGE. THIS INCLUDES FAILURE TO DISCLOSE ANY NEW OR CHANGED FACTS PERTAINING TO THE APPLICATION THAT ARISE AFTER SUBMISSION OF THE APPLICATION BUT BEFORE THE EFFECTIVE DATE OF COVERAGE. THIS RETROACTIVE CANCELLATION IS RESCISSION.

If Blue Shield or Covered California rescinds coverage, Blue Shield will provide the Subscriber with a 30-day written notice. This notice will state:

1. The reason for the rescission;
2. Information about the Subscriber's right to appeal, including the right to request assistance from the Department of Managed Health Care;
3. Clarification that individuals whose application information was not false or incomplete are entitled to new coverage, and:
    a) How those individuals may obtain new coverage; and
    b) How Blue Shield will determine Premiums for those individuals.

After your contract has been in effect for 24 months, Blue Shield or Covered California cannot rescind coverage for any reason. If Blue Shield or Covered California rescinds coverage, the Subscriber and any enrolled Dependents will lose all coverage dating back to the original effective date of coverage. It will be as if coverage never existed.

When Blue Shield or Covered California cancels, does not renew, or rescinds coverage	
Reason	***Date coverage ends***
Failure to pay Premiums in full and on time, including the grace period	30 days after the date on the Notice of Start of Grace Period
Fraud or intentional misrepresentation of a material fact during the application process	The initial effective date of coverage
Fraud or intentional misrepresentation of a material fact after enrollment	30 days after written notice to the Subscriber
Loss of Subscriber eligibility	30 days after written notice to the Subscriber
Loss of Dependent eligibility for a spouse or Domestic Partner	If notice of ineligibility is sent before the 15th of the month: The first day of the month after notice is sent If notice of ineligibility is sent after the 15th of the month: The first day of the second month after notice is sent
Loss of Dependent eligibility for a child	The last day of the year in which the Dependent turns 26
Subscriber changes from one health plan to another during open or special enrollment period	The day before the effective date of coverage in the Subscriber's new plan
Request to enroll a newborn, adopted child, or child placed for adoption is not received within 60 days of the initial coverage date	Day 31 following the initial coverage date
Blue Shield no longer offers this Individual and Family Plan	90 days after written notice to the Subscriber
Blue Shield no longer offers any Individual and Family Plans	180 days after written notice to the Subscriber
Subscriber was enrolled in a Qualified Dental Plan without his or her knowledge or consent by a third party, including by a third party with no connection to Covered California	The initial effective date of coverage

Grace Period

After payment of the first Premiums, the Subscriber is entitled to a grace period of 30 days for the payment of any Premiums due. During this grace period, the Agreement will remain in force. However, the Subscriber will be liable for payment of Premiums accruing during the period the Agreement continues in force.

Grievance Process

Blue Shield of California has established a grievance procedure for receiving, resolving, and tracking Subscribers' grievances. For more information on this process, see the Grievance Process section in the Agreement.

External Independent Medical Review

State law requires Blue Shield to disclose to Members the availability of an external independent review process when your grievance involves a claim or services for which coverage was denied by Blue Shield or by a Participating Dentist in whole or in part on the grounds that the service is not a Medical Necessity or is Experimental or Investigational in Nature. You may choose to make a request to the

Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. For further information about whether you qualify or for more information about how this review process works, see the External Independent Medical Review section in the Agreement.

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 **1-888-271-4880** 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 **(http://www.dmhc.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 reasons of health or utilization of Benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

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 DENTAL 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 Customer Service Department at 1-888-271-4880, or by printing a copy at http://www.blueshieldca.com.

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

Definitions

Terms used throughout this Disclosure Form 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.

Adult – Member 19 years of age and older.

Agreement (Evidence of Coverage and Health Service Agreement) — Evidence of Coverage and Health Service Agreement, Summary of Benefits, all endorsements, appendices, and all applications and forms for coverage.

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.

Benefits (Covered Services) - those services which a Member is entitled to receive pursuant to the terms of the Agreement.

Calendar Year - a period beginning at 12:01 A.M. on January 1 and ending at 12:01 A.M. 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 amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Covered Services (Benefits) - those services which a Member is entitled to receive pursuant to the terms of the Agreement.

Deductible - the Calendar Year amount you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those services.

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 – 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 the Agreement.

Dental Plan Administrator (DPA) - Blue Shield 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. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

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

Dependent -

an individual who meets one of the following eligibility requirements:

1. A spouse who is legally married to the Subscriber and who is not legally separated from the Subscriber.
2. A Domestic Partner to the Subscriber who meets the definition of Domestic Partner as defined in this Agreement.
3. A child who is the child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, 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. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

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) Both partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code.

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

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.

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.

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 - – an individual who is enrolled and maintains coverage in the plan pursuant to this Agreement as either a Subscriber or a Dependent. Use of "you" in this document refers to the Member.

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

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

Pediatric – Members age 0-18 (birth to 18 years of age). Pediatric Benefits are available through the end of the month in which the Member turns 19.

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

Plan - the Blue Shield of California IFP Dental Disclosure (DMHC).

Participating Dentist - a Dental Center, Plan Specialist, or other Dentist who has signed a service contract with a Dental Plan Administrator to provide dental services to Subscribers.

Plan 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 a Participating Dentist.

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

Subscriber - an individual who satisfies the eligibility requirements of this Agreement, and who is enrolled and accepted by Blue Shield of California as a Subscriber, and has maintained Plan membership in accord with the Agreement.