Disclosure

Dental Plan Disclosure Form

Blue Shield Disclosure Form:

Dental PPO and 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 1-888-271-4880 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

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 1-888-271-4880. 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 1-888-271-4880. 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 1-800-286-7401.

DPPO Plans: The names of Participating Dentists in your area may be obtained by contacting a Dental Plan Administrator at 1-888-271-4880. 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 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.

General Exclusions

1. Services not listed as covered in the Member's Agreement/Summary of Benefits;
2. Services to be paid by the Member's Blue Shield health plan;
3. any service, procedure or supply which is received or expenses incurred prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have had expenses incurred 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 services is performed;
4. Services performed or supplies provided in a hospital or any place other than a dental office;
5. Unnecessary, investigational, experimental, cosmetic, or elective services; services for which the prognosis is not favorable, as determined by the Dental Plan Administrator;
6. Services performed by a close relative or someone who lives in the Member's home; services for which the Member is not obligated to pay, or services performed at no charge;
7. Services paid for by any governmental agency;
8. Implants, except when covered in specific plans;
9. Vestibuloplasy, orthognathic surgery, treatment of jaw fractures or TMJ (temporomandibular joint) syndrome;
10. Treatment of congenital anomalies or developmental malformation;
11. Treatment to correct malignancies, cysts, tumors, and neoplasm;
12. Myofunctional therapy, biofeedback procedures, athletic mouth guards, precision or semi-precision attachments, denture duplication;
13. Treatment of accidental or self-inflicted injuries, including setting of fractures and dislocation; Accidental Injury means a condition or injury caused by external, violent or accidental means, rather than by dental illness (e.g. injury caused by a fall or car accident);
14. General anesthesia or intravenous or inhalation sedation, unless Medically Necessary;
15. Prescription or non-prescription drugs;
16. Replacement of appliances (dentures, space maintainers, crowns, etc.) lost or stolen within five years of installation;
17. Removal of wisdom teeth unless of Medical Necessity;
18. Any services Blue Shield or the Dental Plan Administrator determines not to be of Medical Necessity as defined in the Agreement/Summary of Benefits;
19. Temporary dental services. Charges for temporary dental services are considered an integral part of the final dental service and will not be separately payable;
20. 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;

21. 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;
22. 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;
23. Services and/or appliances that alter the vertical dimension, including, not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion, or abrasion, appliances or any other method;
24. Procedures that are principally cosmetic in nature, including, but not limited to, bleaching, veneer facings, crowns, porcelain on molar crowns, personalization or characterization of crowns, bridges and/or dentures; and
25. Charges for saliva and bacterial testing when caries management procedures D0601, D0602, and D0603 are performed.

General Limitations

1. Periodic oral exam, Routine prophylaxis, Fluoride treatment, bitewing X-rays (maximum of four per occurrence), and recementations (if the crown was provided by other than the original Dentist; not eligible if the Dentist is doing the recementation of service he/she provided within 12 months) are Covered Services every 6-month period;
2. Denture (complete and partial) relines and oral cancer screenings (this Benefit only applies to the Dental PPO plan) are Covered Services every 12-month period;
3. Gingival flap surgery per quad, diagnostic casts, sealants, and occlusal guards are Covered Services every 24-month period;
4. Full-mouth debridement, mucogingival surgery per area, Osseous surgery per quad, gingivectomy per quad, gingivectomy per tooth, bone replacement grafts for periodontal purposes, guided tissue regeneration for periodontal purposes, full-mouth series and panoramic X-rays are Covered Services every 36-month period.
5. Single crowns and onlays, single post and core buildups, crown buildup including pins, prefabricated post and core, cast post and core in addition to crown, complete dentures, partial dentures, fixed partial denture (bridge) pontics, fixed partial denture (bridge) abutments, abutment post and core buildups are Covered Services every five-year period.
6. Space maintainers are 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 developed, or will never develop.
7. Sealants are only eligible for Members one per tooth per two-year period through the end of the month in which the Member turns nineteen (19) on permanent first and second molars.
8. Oral surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy, and crown lengthening.
9. 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 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.
10. General IV or inhalation sedation is covered for the following:
    a. Three or more surgical extractions;
    b. One or more impactions;
    c. Full-mouth or arch alveoloplasty;
    d. Surgical root recovery from sinus;
    e. Medical problem contraindicates local anesthesia; and
    f. General or IV sedation is not a covered Benefit for dental-phobic reasons. General or IV sedation is covered for up to thirty minutes per visit;
11. Restorations, crowns, inlays, and onlays are covered only if necessary to treat diseased or accidentally fractured teeth;
12. Root canal treatment is covered one per tooth per lifetime;
13. Root canal retreatment is covered one per tooth per lifetime;
14. Pulpal therapy is covered through age 5 on primary anterior teeth and through age 11 on primary posterior teeth;
15. For mucogingival surgeries, one site is equal to two consecutive teeth or bonded spaces;
16. Scaling and root planing are covered once for each of the four quadrants of the mouth in a 24-month period. Scaling and root planing is limited to two quadrants of the mouth per visit;
17. 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
18. You must be 21 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 or more than 3 teeth missing in a quadrant, or more than 3 teeth missing in the anterior region, 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.

Specific Exclusions & Limitations to Dental HMO plans

In addition to the general exclusions listed above in this section, the following exclusions apply:

1. Services not performed, prescribed, or authorized by the Member's Dentist, unless authorized by the plan or when required in an emergency, as stated in the contract;
2. Precious metals;
3. Services of prosthodontists, and procedures requiring fixed prosthodontic restoration for complete oral rehabilitation or reconstruction;
4. Unauthorized second opinions;
5. House calls for dental services;
6. Dental Implants (Enhanced Dental HMO $0 only) – surgical insertion and/or removal, transplants, ridge augmentations, or socket preservation and appliance and/or crown attached to Implants;
7. Duplicate dentures, prosthetic devices, or any other duplicate appliance;
8. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
9. Treatment in progress (after banding) at inception of eligibility;
10. Surgical Orthodontics (including extraction of teeth) incidental to Orthodontic treatment;
11. Myofunctional therapy;
12. Changes in treatment necessitated by an accident;
13. Treatment for TMJ (temporomandibular joint) disorder or dysfunction;
14. Special Orthodontic appliances, including, but not limited to, Invisalign, lingual, or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
15. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
16. Reimbursement for any services after the 24 months of treatment for which a claim has not been submitted;
17. 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 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 Plan orthodontist's billed charges, prorated for the number of months remaining; and
18. If the Member elects to use the Invisalign system, additional costs beyond what Blue Shield will pay for "standard" Orthodontic treatment (i.e. braces and bands) will be paid by the Member.

Specific Limitations

1. Referral to a specialty care Dentist is limited to Orthodontics, oral surgery, Periodontics, endondontics, and pediatrics;
2. Coverage for referral to a pediatric specialty care Dentist is covered up to the age of 6 years old and is contingent on Medical Necessity. However, exceptions for physical or mental handicaps or medically compromised children over the age of 6 years old, when confirmed by a physician, may be considered on an individual basis with prior approval;
3. Payment for Orthodontic treatment is made in installments. If for any reason Orthodontic services are terminated or coverage is terminated before competition of the approved Orthodontics treatment, the responsibility of the contracted Dental Plan Administrator will cease with payment through the month of termination; and
4. In the case of a dental emergency involving pain or a condition requiring immediate treatment occurring more than 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's Copayment up to a maximum of $50 for each emergency visit.

Specific Exclusions & Limitations to Dental PPO plans

In addition to the general exclusions and limitations listed above in this section, the following exclusions and limitations apply:

1. Any inlay restorations;
2. Crowns or onlays installed as multiple abutments;
3. Prosthetic appliance related to Periodontics;
4. Charges for missed appointments;
5. Alloplastic bone grafting materials;
6. Bone grafting done for socket preservation after tooth extraction or in preparation for Implants; (unless your plan provides special Implant Benefits. Please see the Summary of Benefits to determine if you have Implant Benefits.);
7. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
8. Treatment in progress (after banding) at inception of eligibility;
9. Surgical Orthodontics (including extraction of teeth) incidental to Orthodontic treatment;
10. Treatment for TMJ (Temporomandibular Joint) disorder or dysfunction;
11. Special Orthodontic appliance, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
12. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
13. Treatment exceeding 24 months except for treatment prior approved by Blue Shield as Medically Necessary Dental Services;
14. 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 24 month treatment period, the Member and not a contracted Dental Plan Administrator will be responsible for the remainder of the cost for that treatment at the Plan Orthodontist's billed charges, prorated for the number of months remaining;

15. If the insured is reinstated after cancellation, there are no Orthodontic Benefits for treatment begun prior to his or her reinstatement effective date;
16. There is a 12 month waiting period before beginning Orthodontic treatment;
17. If the Member elects to use the Invisalign system, additional costs beyond what Blue Shield will pay for "standard" Orthodontic treatment (i.e. braces and bands) will be paid by the Member;
18. Benefits for the initial placement will not exceed 20% of the lifetime maximum Benefit amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the Orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits, and procedures performed in connection with the Orthodontic treatment are all subject to the Orthodontia Coinsurance level and lifetime maximum Benefit amount; and
19. Orthodontic Benefits end at cancellation of coverage.

Prepayment Fees

Monthly Dues 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 Dues.

Please call Customer Service at 1-888-256-3650 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 4700
Whittier, CA 90607-4700

Additional Dues may be charged in the event that a State or any other taxing authority imposes upon Blue Shield of California a tax or license fee which is calculated upon base Dues or Blue Shield of California's gross receipts or any portion of either. Dues increase according to the Subscriber's age, as stated in the Appendix. Dues may also increase from time to time as determined by Blue Shield of California. You will receive 60 days' written notice of any changes in monthly Dues for this plan.

Other Charges

Calendar Year Deductible

For dental Plans with a Calendar Year Deductible, the Deductible applies to all Covered Services and supplies furnished by Plan 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 Plan 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 Plan 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 Plan 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 Dues. 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, 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 Dues 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.

Termination of Benefits

This Agreement may be rescinded or terminated as follows:

1. Termination by the Subscriber:

   A Subscriber desiring to terminate this Agreement shall give Blue Shield of California 30 days' notice.

2. Termination by Blue Shield of California through cancellation:

   Blue Shield of California may cancel this Agreement immediately upon written notice for the following reasons:

   a. Fraud or deception in obtaining, or attempting to obtain, Benefits under this Agreement; or

   b. Knowingly permitting fraud or deception by another person in connection with this Agreement, such as, without limitation, permitting someone else to seek Benefits under this Agreement, or improperly seeking payment from Blue Shield of California for Benefits provided.

   Cancellation of the Agreement under this section will terminate the Agreement effective as of the date that written notice of termination is mailed to the Subscriber. It is not retroactive to the original effective date of the Agreement.

3. Termination by Blue Shield of California if Subscriber moves out of Service Area:

   Blue Shield of California may cancel this Agreement upon thirty (30) days written notice if the Subscriber moves out of California. See the section entitled "Transfer of Coverage" for additional information.

   Within 30 days of the notice of cancellation under sections 3 or 4, above, Blue Shield of California shall refund the prepaid Dues, if any, that Blue Shield of California determines will not have been earned as of the termination date. Blue Shield of California reserves the right to subtract from any such Dues refund any amounts paid by Blue Shield of California for Benefits paid or payable by Blue Shield of California after the termination date.

4. Termination by Blue Shield of California due to withdrawal of the Agreement from the market:

   Blue Shield of California may terminate this Agreement together with all like Agreements to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll on any other individual agreement without regard to health status-related factors.

5. Cancellation by Blue Shield for Subscriber's nonpayment of Dues:

   Blue Shield of California may cancel this Agreement for failure to pay the required Dues, when due. If the Agreement is being cancelled because you failed to pay the required Dues when due, then coverage will end 30 days after the date for which these Dues are due. You will be liable for all Dues accrued while this Policy continues in force including those accrued during this 30-day grace period.

   Within five business days of canceling or not renewing the Agreement, the Plan will send you a Notice of End of Coverage, which will inform you of the following:

   a. That the Agreement has been cancelled, and the reasons for cancellation; and

   b. The specific date and time when coverage for you and all your Dependents ended.

Grace Period

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

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 **1-888-271-4880** 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 **(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.

Allowable Amount -

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

DPPO Plans: a Dental Plan Administrator Allowance (as defined below) for the service (or services) rendered, or the provider's billed charge, whichever is less. A Dental Plan Administrator allowance is:

1. the amount a Dental Plan Administrator has determined is an appropriate payment for the Service(s) rendered in the provider's geographic area, based upon such factors as evaluation of the value of the Service(s) relative to the

value of other Services, market considerations, and provider charge patterns; or

2. such other amount as the Participating Dentist and a Dental Plan Administrator have agreed will be accepted as payment for the Service(s) rendered; or

3. if an amount is not determined as described in either 1. or 2. above, the amount a Dental Plan Administrator determines is appropriate considering the particular circumstances and the Services rendered.

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 -

1. a Subscriber's legally married spouse or Domestic Partner who is:

   a. a Resident of California (unless a full-time student); and

   b. not covered for Benefits as a Subscriber; and

   c. not legally separated from the Subscriber; or,

2. 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 and who has been enrolled and accepted by Blue Shield of California as a Dependent and has maintained membership in accordance with the Agreement.

   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.

3. 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 child will be continued upon the following conditions:

   a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

   b. the Subscriber, spouse, or Domestic Partner must submit 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 twenty-four (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. Both partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code.

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

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

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 - either a Subscriber or an eligible Dependent.

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.

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.

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).

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.

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.

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)**。