blue california

Evidence of Coverage

NEXT PHASE ELECTRIC INC
01/01/2023
Smile(SM) Value 50/1500/No Ortho/MAC

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SmileSM Value 50/1500/No Ortho/MAC

(Available to groups from 1-100)

Evidence of Coverage

Group

Evidence of Coverage

Blue Shield of California
SmileSM Value 50/1500/No Ortho/MAC

NOTICE

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

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

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

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Blue Shield Customer Service at the address or telephone number listed at the back of this booklet.

This booklet constitutes only a summary of the dental care Plan. The group Plan Contract must be consulted to determine the exact terms and conditions of coverage.

The group Contract is on file with your Employer and a copy will be furnished upon request.

NOTICE

Please read this Evidence of Coverage booklet carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your dental coverage.

Should you have any questions regarding your Blue Shield of California dental Plan, see your Employer or contact any of the Blue Shield of California offices listed on the last page of this booklet.

IMPORTANT

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

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

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

IMPORTANT

If you opt to receive dental services that are not Covered Services under this Plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Member Services at 1-888-702-4171 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.

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blue of california

Summary of Benefits

Group Dental Plan
DPPO Plan

Smile℠ Value 50/1500/No Ortho/MAC

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

Dental Provider Network: DPPO Network

This Plan uses a specific network of dental care providers, called the DPPO provider network. Dentists in this network are called Participating Dentists. You pay less for Covered Services when you use a Participating Dentist than when you use a Non-Participating Dentist. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductible (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Dentist
Calendar Year Deductible	*Individual coverage*	$50 per individual
	Family coverage	$50: individual $150: Family

Calendar Year Benefit Maximum[5]

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

	When using any combination of Participating[3] and Non-Participating[4] Dentists	When Using a Non-Participating Dentist[4]
Calendar Year Benefit Maximum	$1,500: individual	$750: individual

Waiting Period

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

Waiting period	No waiting period

No Lifetime Dollar Limit

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

Benefits[6,7,8]	Your payment			
	When using a Participating Dentist[3]	CYD[2] applies	When using a Non-Participating Dentist[4]	CYD[2] applies
Diagnostic and preventive services				
Oral exam	$0		20%	
Preventive – cleaning	$0		20%	
Preventive – x-ray	$0		20%	
Topical fluoride application	$0		20%	
Periodontal maintenance	$0		20%	
Enhanced dental benefits for pregnant women	$0		$0	
Basic services				
Sealants per tooth	20%	✔	30%	✔
Space maintainers – fixed	20%	✔	30%	✔
Restorative procedures	20%	✔	30%	✔
Major services				
Oral Surgery	50%	✔	50%	✔
Endodontics	50%	✔	50%	✔
Periodontics (other than maintenance)	50%	✔	50%	✔
Crowns and casts	50%	✔	50%	✔
Prosthodontics	50%	✔	50%	✔
Implants	Not covered		Not covered	
Orthodontics	Not covered		Not covered	

Dental Smile Rollover Rewards[9]

Initial Maximum Calendar Year Benefit	Annual Claim Threshold	Annual Account Reward	Annual Network Reward	Total Annual Reward	Total Reward Account Maximum	Potential Maximum Calendar Year Benefit (Initial Maximum Calendar Year Benefit + Total Reward Account Maximum)
$750	$250	$125	$100	$225	$750	$1,500

Notes

1 Evidence of Coverage (EOC):

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

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

2 Calendar Year Deductible (CYD):

Notes

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

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year Deductible. Some Covered Services are paid by Blue Shield before you meet any Calendar Year Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Any amount you have paid toward the Deductible for your individual plan will be applied to both the individual Deductible and the Family Deductible for your new plan.

3 Using Participating Dentists:

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

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Dentists:

Non-Participating Dentists do not have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Non-Participating Dentist, you are responsible for both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount (which can be significant).

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards any Benefit maximums, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

The Non-Participating Dentist reimbursement amount is a percentage of the maximum allowable charge or MAC. When you go to a Non-Participating Dentist, you pay the amount above the MAC percentage.

5 Benefit Maximum(s):

Your payment after you reach any Benefit maximum. You will pay 100% of all charges after you reach a Benefit maximum.

All Covered Services count towards the Calendar Year Benefit maximum. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

*This Plan has a combined Participating Dentist and Non-Participating Dentist Calendar Year Benefit maximum as well as a Non-Participating Dentist Benefit maximum***.** This means that any amount the Plan pays towards Covered Services for Non-Participating Dentists also counts towards the combined Participating and Non-Participating Dental Benefit maximum.

Enhanced dental benefits for pregnant women do not apply towards the Calendar Year Benefit Maximum.

Notes

6 Separate Member Payments When Multiple Covered Services are Received:

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

7 Dental Care Services:

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

8 Prior Authorization:

Prior Authorization or precertification for Covered Services. Before any course of treatment expected to cost more than $250 is started, you should obtain prior authorization of Benefits, except in an emergency.

9 Dental Smile Rewards Program:

With the Dental Smile Rollover Rewards Program, Blue Shield rewards you for getting diagnostic and preventive care from your Dentist during the year. Your reward accumulates, will be carried over each year, and is available for use beginning in the next benefit period (see the Dental Smile Rollover Rewards section of the Evidence of Coverage for details on how the program works).

If the Member's Plan has different Participating and Non-Participating Initial Maximum Calendar Year Benefits, the Annual Account Reward amount will be determined by the Non-Participating Initial Maximum Calendar Year Benefit amount.

Introduction to the Blue Shield of California Dental PPO Plan

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

Your interest in Blue Shield of California Dental PPO Plan is truly appreciated. Blue Shield of California (**from this point forward referred to as "the Plan" or "Blue Shield")** has been serving Californians for over 60 years, and we look forward to serving your dental care needs.

Blue Shield's dental plans are administered by Dental Plan Administrator (DPA), which is an entity that contracts with Blue Shield of California to administer the 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.

Before Obtaining Dental Services:

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 any 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 1-888-702-4171. You may also access a list of Participating Dentists through Blue Shield's Internet site located at http://www.blueshieldca.com. You are also responsible for following the Precertification of Dental Benefits Program which includes obtaining or assuring that the Participating or Non-Participating Dentist obtains precertification of Benefits.

NOTE: A Dental Plan Administrator will respond to all requests for precertification and prior authorization within 5 business days from receipt of the request. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a Dental Plan Administrator will respond within 72 hours from receipt of the request.

Failure to meet these responsibilities may result in the denial of Benefits. However, by following the precertification process both you and the Dentist will know in advance which services are covered and the Benefits that are payable.

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

Participating Dentists

The Blue Shield of California Dental PPO Plan is specifically designed for you to use Participating Dentists.

Participating Dentists agree to accept a Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Copayment or 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 Covered 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 Dentists submit claims for reimbursement 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.

Blue Shield contracts with hospitals and physicians to provide services to Members for specified rates. This contractual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the contract. If you want to know more about this payment system, contact Customer Service at the number provided on the back page of this booklet.

A list of Participating Dentists located in your area can be obtained by contacting a Dental Plan Administrator at 1-888-702-4171. You may also access a list of Par-

ticipating Dentists through Blue Shield's Internet site located at http://www.blueshieldca.com.

Timely Access to Dental Care Services

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

Service	Access to Care
Urgent Care	Within 72 hours
Non-urgent care	Within 30 business days
Preventive dental care	Within 40 business days
Telephone Inquiries	**Access to Care**
Access to a dental professional to evaluate the Member's dental concerns and symptoms	Within 30 minutes, 24 hours/day 7 days/week

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

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.

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.

Eligibility

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

Newborn infants of the Subscriber, spouse, or his or her Domestic Partner will be eligible immediately after birth for the first 31 days. A child placed for adoption will be eligible immediately upon the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Subscriber's, spouse's or Domestic Partner's right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to and received by Blue Shield within 60 days from the date of birth or placement for adoption of such Dependent.

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

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

1. to continue coverage of a newborn or child placed for adoption;
2. to add a spouse after marriage or add a Domestic Partner after establishing a domestic partnership;
3. to add yourself and spouse following the birth of a newborn or placement of a child for adoption;
4. to add yourself and spouse after marriage;
5. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

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

If both partners in a marriage or domestic partnership are eligible to be Subscribers, children may be eligible and

may be enrolled as a Dependent of either parent, but not both.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician's written certification of such disabling condition. Blue Shield or the Employer will notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician's written certification within 60 days of the request for such information by the Employer or by Blue Shield. Proof of continuing disability and dependency must be submitted by the Employee as requested by Blue Shield but not more frequently than two years after the initial certification and then annually thereafter.

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

Duration of the Agreement

This agreement shall be renewed upon receipt of prepaid Dues. Renewal is subject to the Plan'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.

Effective Date of Coverage

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

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

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

Once each Calendar Year, your Employer may designate a time period as an annual Open Enrollment Period. During that time period, you and your Dependents may transfer from another dental plan sponsored by your Employer to this Plan. A completed enrollment form must be forwarded to Blue Shield within the Open Enrollment Period. Enrollment becomes effective on the anniversary date of this Plan following the annual Open Enrollment Period.

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

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

If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child, under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or re-

quest by a custodial party, as described in Section 3751.5 of the California Family Code.

If you or your Dependents voluntarily discontinued coverage under this Plan and later request reinstatement, you or your Dependents will be covered the earlier of 12 months from the date of request for reinstatement or at the Employer's next Open Enrollment Period.

Commencement or Termination of Coverage

Whenever this agreement provides for a date of commencement or termination of any part of all of the coverage herein, such commencement or termination shall be effective at 12:01 A.M. Pacific Time on the commencement date and as of 11:59 P.M. Pacific Time on the termination date.

DEDUCTIBLE

Calendar Year Deductible

For 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 which is attached to and made a part of this EOC. 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, except that no more than the Family Deductible amount is required of a Family in a 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 and Family Deductible amounts, if applicable, are listed in the Summary of Benefits which is attached to and made a part of this EOC.

ACCRUAL BALANCE

You can check your accrual balances toward your Calendar Year Deductible and Maximum Calendar Year Benefit at any time by logging into your member portal online, which is updated daily, or calling Customer Service at the number on the back of your ID card. Your accrual balances will also be included on the explanation of Benefits you receive once a claim has been received and processed.

PRECERTIFICATION OF DENTAL BENEFITS PROGRAM

Before any course of treatment expected to cost more than $250 is started, you should obtain precertification of Benefits. Note: If your Plan provides special Implant Benefits, you must obtain precertification/prior authorization for these Benefits before services are provided or Benefits will be denied.

Your Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic x-rays to a Dental Plan Administrator. A Dental Plan Administrator will review the dental treatment plan to determine the Benefits payable under the Plan. The Benefit determination for the proposed treatment plan will then be promptly returned to the Dentist. When the treatment is completed, your claim form should be submitted to a Dental Plan Administrator for payment determination. A Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

The dental Plan provides Benefits for Covered Services at the most cost effective level of care that is consistent with professionally recognized standards of care. If there are two or more professionally recognized procedures for treatment of a dental condition, the Plan will in most cases provide Benefits based on the most cost effective procedure. The Benefits provided under the Plan are based on these considerations but you and your Dentist make the final decision regarding treatment.

If your Plan provides special Implant Benefits, failure to obtain precertification/prior authorization of these Benefits will result in a denial of Benefits. For all other Benefits, failure to obtain precertification of Benefits will not necessarily result in a denial of Benefits. If the precertification process is not followed, a Dental Plan Administrator will still determine payment by taking into account alternative procedures, services or materials for the dental condition based on professionally recognized standards of dental practice. However, by following the precertification process both you and your Dentist will know in advance which services are covered and the Benefits that are payable.

The covered dental expense will be limited to the Allowable Amount for the procedure, service or material

which meets professionally recognized standards of quality dental care and is the most cost effective as determined by a Dental Plan Administrator. If you and your Dentist decide on a more costly procedure, service or material than a Dental Plan Administrator determined is payable under the Plan, then Benefits will be applied to the selected treatment plan up to the Benefit maximum for the most cost effective alternative. You will be responsible for any charges in excess of the Benefit amount. A Dental Plan Administrator reserves the right to use the services of dental consultants in the Precertification review.

Example:

1. If a crown is placed on a tooth which can be restored by a filling, Benefits will be based on the filling;
2. If a semi-precision or precision partial denture is inserted, Benefits may be based on a conventional clasp partial denture;
3. If a bridge is placed and the patient has multiple unrestored missing teeth, Benefits will be based on a partial denture.

Blue Shield Dental Smile Rollover Rewards

With the Dental Smile Rollover Rewards Program, Blue Shield rewards Members for seeking diagnostic and preventive services each year. Members can accumulate rewards in the current Benefit period, which will be carried over each year and are available for use beginning in the next Benefit period. As explained further below, the rewards can increase your Initial Maximum Calendar Year Benefit.

How to Qualify for the Dental Smile Rollover Rewards Program

- Member must be enrolled in the plan prior to the last three months of the current Benefit period (October – December).

- If the Member joins the plan during the last three months of the current Benefit period, the Member will have to wait until the end of the first full month of the next Benefit period to participate in the Dental Smile Rollover Rewards Program.

For example:

Current Benefit period is January 1, 2018 – December 31, 2018

If Member joins the plan on…	Will Member qualify for the Dental Smile Rollover Rewards Program?
January 1, 2018	Yes
April 1, 2018	Yes
November 1, 2018	No, Member will have to wait until February 1, 2019 before Member can participate

- Once qualified, the Member can begin to accrue Rollover Rewards, which will be available in the next Benefit Period.

- If the Member ends coverage but returns within six (6) months with the same employer, the Member can rejoin the program without any loss of his/her previously unused reward balance, as long as the Member's employer still offers a dental plan with the Dental Smile Rollover Rewards Program.

- If the Member's employer decides to change the Member's dental plan, then as long as the Member's new dental plan includes the Dental Smile Rollover Rewards Program, the Member will retain his/her rewards balance earned under the old plan. If the Member's new plan does not include the Dental Smile Rollover Rewards Program, the Member will lose his/her rewards balance.

How the Dental Smile Rollover Rewards Program works

- The Member must qualify for the Dental Smile Rollover Rewards Program, as explained above.

- Each individual Member qualifies for and receives Annual Account Rewards separately.

- The Member's Dental Smile Rollover Rewards Program has an Annual Claim Threshold. The

Member must submit claims for services provided by a Non-Participating Dentist.

- If all non-emergency services during the Calendar Year are provided by Participating Dentists, the Member earns an additional Annual Network Reward of $100. This amount will be added to the Annual Account Reward amount.

- If the Member's Plan has different Participating and Non-Participating Initial Maximum Calendar Year Benefits, the Annual Account Reward amount will be determined by the Non-Participating Initial Maximum Calendar Year Benefit amount.

- The Annual Account Reward can be used for diagnostic and preventive services as well as other covered services provided by either Participating or Non-Participating Dentists.

- If the Member's submitted claims amount is less than or equal to the Annual Claim Threshold for the Calendar Year, the Total Reward Account Maximum amount will be added to the following year's Initial Maximum Calendar Year Benefit.

- At the end of each Calendar Year, the Member's Total Annual Reward plus any previously earned unused amount (up to the Total Reward Account Maximum amount) will be applied to the next year's Initial Maximum Calendar Year Benefit.

    1. By carrying over unused rewards from one Calendar Year to the next, the Member can earn up to the Total Reward Account Maximum that produces an overall Potential Maximum Calendar Year Benefit.

Find your plan's Potential Maximum Calendar Year Benefit to see your rewards and maximums:

Your Initial Maximum Calendar Year Benefit is	Your Annual Claim Threshold amount is less than or equal to	Your Annual Account Reward is	Your Annual Network Reward if you see a Participating Dentist	Your Total Annual Reward (Annual Account Reward + Annual Network Reward) is	Your Total Reward Account Maximum (Maximum amount you can accumulate at a time) is	Your Potential Maximum Calendar Year Benefit (including Total Reward Account Maximum) is
$1,000	$500	$250	$100	$350	$1,000	$2,000
$1,500	$500	$250	$100	$350	$1,000	$2,500
$2,000	$500	$250	$100	$350	$1,000	$3,000

Limitations of the Dental Smile Rollover Rewards Program

- All non-emergency services during the Calendar Year must be provided by Participating Dentists.

- The Member will not earn the Annual Account Reward amount or be eligible for the Annual Network Reward if either of the following occur:

    1. Claims amount for services provided by any Dentist during the Calendar Year is more than the Annual Claim Threshold.

    2. Claims are submitted for services provided by a Non-Participating Dentist (other than for emergency services).

- Orthodontic claims do not qualify as submitted claims for purposes of the Dental Smile Rollover Rewards Program.

- If the Member's Plan has different Participating and Non-Participating Initial Maximum Calendar Year Benefits, the reward amounts will be added to the Non-Participating Initial Maximum Calendar Year Benefit amount.

- Claims for services provided by a Non-Participating Dentist must be submitted to Blue Shield within 180 days of receiving the service to qualify as submitted claims for purposes of the Dental Smile Rollover Rewards Program. Please see the Reimbursement Provisions section of this EOC for the Procedure for Filing a Claim.

PAYMENT

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.

The maximum per Member, per Calendar Year amount payable by Blue Shield for Covered Services and sup-

plies 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 EOC.**

**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 EOC.

Participating Dentists

Services rendered by Participating Dentists are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount.

When a Benefit of the Plan, services rendered for Orthodontic services are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount as well as all charges for services in excess of the Benefit maximum.

Non-Participating Dentists

Services rendered by Non-Participating Dentists are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount, as well as any charges above the Allowable Amount.

When a Benefit of the Plan, services rendered for Orthodontic services are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount. Subscribers are also responsible for any charges above the Allowable Amount as well as all charges for services in excess of the Benefit maximum.

Payment by a Dental Plan Administrator or Blue Shield of California for Covered Services will be made on the basis of the Allowable Amount as determined by Blue Shield of California.

Participating Dentists will be paid directly by the Plan, and have agreed to accept a Dental Plan Administrator payment, plus your payment of any applicable Deductible or Coinsurance amount, as payment in full for Covered Services.

Payment by Blue Shield of California for services rendered by a Non-Participating Dentist, plus your payment of the applicable Deductible and Coinsurance amount, may or may not be accepted by a Non-Participating Dentist as payment in full. Therefore, you may have to pay an amount in addition to the Coinsurance amount. Blue Shield of California suggests that you discuss this beforehand with your Dentist if he is not a Participating Dentist. Any difference between the Blue Shield of California payment and the Non-Participating Dentist's charges are your responsibility.

If the covered Member recovers from a third party the reasonable value of Covered Services rendered by a Participating Dentist, the Participating Dentist who rendered these services is not required to accept the fees paid by a Dental Plan Administrator as payment in full, but may collect from the covered Member the difference, if any, between the fees paid by a Dental Plan Administrator and the amount collected by the covered Member for these services.

Waiting Period

Some plans have a 12-month waiting period for Major Services and Orthodontics. A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services. Please see your Summary of Benefits to determine if your plan has a waiting period. If you had prior comprehensive coverage, the waiting period may be waived. For more information and to see if you qualify, please contact Member Services at [1-888-702-4171].

Out-of-State and Foreign Claims

Out-of-state claims will be paid in the same manner as in-state claims. Services rendered by a participating national provider are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount.

Claims for services rendered by a non-participating national provider or out-of-country provider are paid at the Non-Participating Dentist percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount as well as any charges above the Allowable Amount. When you receive services from an out-of-

state, non-participating national provider or out-of-country provider, you will have to pay the provider and then submit a Claim.

Please see the *Reimbursement Provision* section of this EOC for the Procedure for Filing a Claim.

Principal Benefits and Coverages

The Benefits of the Plan are listed in the Summary of Benefits which is inserted as part of this booklet. Blue Shield payments for these services, if applicable, are also listed in the Summary of Benefits.

Important Information

Services are Benefits of the Plan when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit descriptions below, and to the Limitations and Exclusions listed in this booklet.

Benefits of the Plan are provided for services customarily performed by licensed Dentists for treatment of teeth, jaws and their dependent tissues.

Payments are based on the Allowable Amount as defined, and are subject to the dental Benefit Deductible, the indicated Coinsurance amount percentages, and all Benefit maximums as specified in the Summary of Benefits.

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

Diagnostic and Preventive Services

Diagnostic and preventive services provided by Participating Dentists will be covered at 100%, subject to the limitations in the General Limitations section and are not subject to the Calendar Year Deductible.

Enhanced Dental Benefits for Pregnant Women

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

Additional Benefits for women during pregnancy include:

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

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

Telehealth Services

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

Limitations and Exclusions

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. charges for Implants or the removal of Implants (surgically or otherwise) and any appliances and/or crown attached to Implants unless your Plan provides special Implant Benefits. Please see the Summary of Benefits to determine if you have Implant Benefits;
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 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 Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;

4. 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;
5. 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);
6. all prescription and non-prescription drugs;
7. charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
8. 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;
9. 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;
10. procedures which are principally cosmetic in nature, such as bleaching, veneers, and personalization or characterization of dentures;
11. the replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) within five (5) years of its installation;
12. myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures;
13. orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;
14. charges for services in connection with orthodontia, except as listed under Orthodontic services;
15. alloplastic bone grafting materials;
16. 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.);
17. charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
18. extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
19. any procedure not performed in a dental office setting; except for general anesthesia when Medically Necessary;
20. dental services performed in a hospital or any related hospital fee;
21. 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;
22. services for which the Member is not legally obligated to pay, or for services for which no charge is made;
23. treatment as a result of Accidental Injury including setting of fractures or dislocation;
24. treatment for which payment is made by any governmental agency, including any foreign government;
25. charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
26. charges for onlays or crowns installed as multiple abutments;
27. any inlay restorations;
28. charges for dental appointments which are not kept, except as specified under the Summary of Benefits;

29. charges for services incident to any intentionally self-inflicted injury;

30. 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 covered oral surgery procedures and generally accepted professional standards; and

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

    c. due to the existence of a specific medical condition;

    Patient apprehension or patient anxiety will not constitute Medical Necessity.

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

31. removal of 3rd molar (wisdom teeth) other than for Medical Necessity. Medical Necessity is pertaining to the removal of 3rd molar (wisdom teeth) is defined as a pathological condition which includes horizontal, mesial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not a Medical Necessity;

32. 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;

33. any service, procedure, or supply which is received or started 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 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.

34. for services provided by an individual or entity that is not licensed or certified by the state to provide health-Dental Care Services, or is not operating within the scope of such license or certification, except as specifically stated herein;

35. charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;

36. any and all Implant services that have not been prior authorized and approved by a 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.

Orthodontic Limitations and Exclusions

1. treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;

2. surgical Orthodontics (including extraction of teeth) incidental to Orthodontic treatment;

3. treatment for myofunctional therapy;

4. changes in treatment necessitated by an accident;

5. treatment for TMJ (temporomandibular joint) disorder or dysfunction;

6. special Orthodontic appliances, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;

7. replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;

8. treatment exceeding twenty-four (24) months for treatment prior approved by Blue Shield as Medically Necessary;

9. in the event of an insured's loss of coverage for any reason, if at the time of loss of coverage the insured is still receiving Orthodontic treatment during the twenty-four (24) month treatment period, the insured and not the Dental Plan Administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's Billed

Charges, prorated for the number of months remaining;

10. if the insured is reinstated after cancellation, there are no Orthodontic Benefits for treatment begun prior to his or her reinstatement effective date;
11. if the Member elects to use invisalign®, lingual or invisible braces, sapphire or clear braces, additional costs beyond what BSC will pay for "standard" Orthodontic system of brackets and wires will be paid by insured.

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

Medical Necessity Exclusion

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

Alternate Benefit Provision

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the dental Plan will pay Benefits based upon the less costly service.

General Limitations

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

1. one (1) in a six (6) month period:
   A. periodic oral exam, including consultations by a specialist (if diagnostic service is provided by a Dentist or physician other than the treating provider);
   B. fluoride treatment for eligible Members through the end of the month in which the Member turns nineteen (19);
   C. bitewing x-rays (two (2) sets of single films or one (1) set of two (2) films);
   D. recementations if the crown or inlay was provided by other than the original Dentist; not eligible if the Dentist is doing the recementation of a service he/she provided within twelve (12) months;
   E. periodontal prophylaxis (recall or maintenance) not more than a combined total of of one (1) periodontal and/or regular prophylaxis per each period of six (6) consecutive months.
2. one (1) in a twelve (12) month period:
   A. denture (complete or partial) reline;
   B. oral cancer screening:
      - adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures;
   C. bitewing x-rays (three films or four films).
3. one (1) in twenty-four (24) months:
   A. sealants through the end of the month in which the Member turns nineteen (19) on permanent first and second molars;
   B. occlusal guards;
   C. diagnostic casts:
      - working models taken in conjunction with a prosthetic or other appliance are not considered to be diagnostic casts;
   D. gingival flap surgery per quad;
   E. scaling and root planing per quadrant.
4. one (1) in thirty-six (36) months:
   A. mucogingival surgery per area;
   B. osseous surgery per quad;
   C. gingivectomy per quad;
   D. gingivectomy per tooth;
   E. bone replacement grafts for periodontal purposes;
   F. guided tissue regeneration for periodontal purposes;
   G. full mouth series and panoramic x-rays includes ten (10) to fourteen (14) periapical x-rays and supplementary bitewing films:
   H. X-rays required to diagnose a specific condition are not subject to limitations stated above;
   I. full mouth debridement;
   J. intraoral x-rays – complete series
      - including bitewings;
   K. panoramic film.
5. one (1) in a five (5) year period:
   A. single crowns and onlays;
   B. single post and core buildups;
   C. crown buildup including pins;
   D. prefabricated post and core;
   E. cast post and core in addition to crown;

F. complete dentures;
G. partial dentures;
H. fixed partial denture (bridge) pontics;
I. fixed partial denture (bridge) abutments;
J. abutment post and core buildups.

6. two (2) in a consecutive twelve (12) month period:
   A. routine prophylaxis;

7. space maintainers – including all adjustments within six (6) months after installation and are limited to Members when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop;

8. child fluoride and child prophylaxis – one per six month period through the end of the month in which the Member turns nineteen (19);

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

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

10. oral surgery services are limited to removal of teeth, bony protuberances, frenectomy, radical excision of small (to 1.25 cm) non-malignant lesions, and other surgical procedures which includes local anesthesia and routine pre and post-operative care;

11. 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 he applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP;

12. 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 the use of local anesthesia;
   F. children under the age of seven (7) years old.
   G. General or IV sedation is not a covered Benefit for dental phobic reasons. Deep sedation/general anesthesia is covered for up to one hour per visit;

13. restorations, crowns, inlays and onlays - covered only if necessary to treat diseased or accidentally fractured teeth and when the tooth cannot be restored with a filling material;

14. root canal treatment – one per tooth per lifetime;

15. root canal retreatment – one per tooth per lifetime;

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

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

18. you must be age 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 and/or non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If there are more than three teeth missing and/or more than three non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If the Member elects a different procedure, payment will be based on the partial denture Benefit;

19. 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;

20. Endodontics - Pulp capping; therapeutic pulpotomy — deciduous teeth only (in addition to restoration); vital pulpotomy — deciduous teeth only; apexification; root canals on permanent teeth only, including pulpotomy or other palliative treatment and necessary x-rays and cultures, but excluding final restoration; root canal therapy; apicoectomy (including apical curettage);
21. Palliative (emergency treatment) – Only for immediate relief of pain or swelling to medically stabilze the dental issue or problem and can be used only once per month for same condition;
22. Periodontics – covered for emergency treatment including:
    A. periodontal abscess;
    B. acute periodontitis;
    C. root planing (not prophylaxis);
    D. subgingival curettage;
    E. debridement;
    F. gingival surgery (including post surgical visits);
    G. osseous surgery (including post surgical visits).
23. Cast restorations - Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a filling material. Cast restorations (onlays, and other laboratory prepared restorations); crowns (acrylic, composite glass, porcelain and gold); veneers; post and cores; crown buildups (on vital or non-vital teeth when functionally necessary). Repair or recementing of onlays and crowns is covered for six (6) months after installation;
24. Implants – When a Benefit of your Plan, single tooth implant is offered for initial replacement of any missing single tooth except second and third molars and lower anterior teeth. Failed implant, second and third molar and lower anterior tooth replacement are not included. Benefits include the surgical implant placement, bone grafting to the site (if required), abutment that screws into the implant body (if one is utilized) and the prosthetic crown that is supported by the surgical implant. Benefits are provided for the maintenance, repair and removal of the implant;
25. Prosthetics - Bridges, dentures, partials and relining or rebasing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stay plate, special tissue conditioning per denture (limited to one course of treatment per 6 month period). Fees for appliances include adjustments, repairs, and relines for a 6 month period following installation. An additional Benefit for one reline per immediate denture is payable during the first 6 months following installation. There is no coverage for replacement of an existing partial denture, full removable denture, implant or fixed bridgework which is less than 5 years old. Upgrading from a partial denture to fixed bridgework will be payable only if acceptable documentation is presented which clearly demonstrates that the patient's arch cannot be adequately restored with a partial denture.

LIMITATIONS FOR DUPLICATE COVERAGE

When you are eligible for Medi-Cal

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

When you are a qualified veteran

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

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Blue Shield group Plan will equal, but not exceed, what Blue Shield or a Dental Plan Administrator would have paid if you were not eligible to receive benefits under that cover-

age (based on the reasonable value or Blue Shield's or a Dental Plan Administrator's Allowable Amount).

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how Blue Shield or a Dental Plan Administrator coordinates your group Plan benefits in the above situations.

Exception for Other Coverage

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

Reductions — Third Party Liability

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield or a Dental Plan Administrator shall, with respect to services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for services provided to the Member paid by Blue Shield or a Dental Plan Administrator on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage. This right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Member has been "made whole" by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The covered Member is required to:

1. Notify Blue Shield or a Dental Plan Administrator in writing of any actual or potential claim or legal action which such covered Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide a lien calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield and a Dental Plan Administrator, in writing, within ten (10) days after any Recovery has been obtained.

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

Reinstatement, Cancellation and Rescission Provisions

Reinstatement

If you and your Dependents voluntarily cancelled coverage, you may apply for reinstatement. You or your Dependents must wait the earlier of, 12 months from the date of application to be reinstated, or at the Employer's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

Cancellation Without Cause

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

Cancellation for Non-payment of Dues - Notices

Blue Shield of California may cancel the group dental Plan for non-payment of Dues. If your Employer fails

to pay the required Dues when due, coverage will end the day following the 30-day grace period. Your Employer will be liable for all Dues accrued while this Plan continues in force including those accrued during the 30 day grace period. Blue Shield of California will send you and your Employer a Notice of End of Coverage no later than five calendar days after the date of coverage.

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

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

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

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

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

Right of Cancellation

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

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

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

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

Termination of Benefits

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

Coverage for you or your Dependents terminates at 11:59 P.M. Pacific Time on the earliest of these dates: (1) the date the Group Dental Service Contract is discontinued, (2) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and your Employer, (3) the date as indicated in the Notice of End of Coverage that is sent to the Employer (see "Cancellation for Non-Payment of Dues – Notices"), or (4) on the last day of the month in which you or your Dependents become ineligible. A spouse also becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see your Employer about possibly continuing group coverage. Also see, if applicable, the Continuation of Group Coverage provision in this booklet for information on continuation of coverage.

If your Employer is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), your payment of Dues will keep your coverage in force for such period of time as specified in such Act(s). Your Employer is solely responsible for notifying you of the availability and duration of family leaves. If written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 31 days following that Dependent's effective date of coverage, Benefits under the Plan will

be terminated on the 31st day at 11:59 P.M. Pacific Time.

Additionally, Blue Shield may terminate coverage if:

(1) There is a violation of a material contract provision relating to Employer contribution or group participation rates by the Contractholder/Employer;

(2) Blue Shield terminates a particular product or all products offered in the large group market as permitted or required by law. If Blue Shield discontinues offering a particular product in a market, Blue Shield will send you written notice at least 90 days before the product terminates. If Blue Shield discontinues offering all products to groups in the large group market, Blue Shield will send you written notice at least 180 days before the Contract terminates;

(3) A Member or Employer ceases to be a member of a guaranteed association.

Liability of Subscribers in the Event of Nonpayment by Blue Shield of California

In accordance with Blue Shield of California's established policies, and by statute, every Contract between a Dental Plan Administrator and its Participating Dentists stipulates that the Subscriber shall not be responsible to the Participating Dentist for compensation for any services to the extent that they are provided in the Subscriber's group Contract. When services are provided by a Participating Dentist, the Subscriber is responsible for any applicable Deductible, Coinsurance or Copayment amounts, and charges in excess of Benefit maximums.

If services are provided by a Non-Participating Dentist, the Subscriber is responsible for any amount Blue Shield of California does not pay.

When a Benefit specifies a maximum allowance and the Plan's maximum has been reached, the Subscriber is responsible for any charges above the Benefit maximum amounts.

Prepayment Fee

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

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

The Dues payable under this Plan may be changed from time to time, for example, to reflect new Benefit levels. Your Employer will receive notice from the Plan of any changes in Dues at least 60 days prior to the change. Your Employer will then notify you immediately. Note: This paragraph does not apply to a Subscriber who is enrolled under a Contract where monthly Dues automatically increase, without notice, the first day of the month following an age change that moves the Subscriber into the next higher age category.

Plan Changes

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

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

Notice

The Subscriber hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Subscriber and Blue Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield service mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than the Plan and that neither the Association nor any person, entity, or organization affiliated with the Association shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this

Agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Agreement.

Blue Shield Online

Blue Shield's Internet site is located at http://www.blueshieldca.com. Members with Internet access and a Web browser may view and download healthcare information.

Choice of Providers

Under the Blue Shield of California Dental PPO plans, you have a free choice of any licensed Dentist including such providers outside of California.

Facilities (Participating Dentist)

The names of Participating Dentists in your area may be obtained by contacting a Dental Plan Administrator at 1-888-702-4171. You may also access a list of Participating Dentists through Blue Shield's Internet site located at http://www.blueshieldca.com.

Utilization Review

State law requires that health plans disclose to Subscribers and health plan providers the process used to authorize or deny health care 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 1-888-702-4171.

Notices

Any notice required by this Agreement may be delivered by United States mail, postage pre-paid. Notice to the Subscriber may be mailed to the address appearing on the records of Blue Shield of California and notice to Blue Shield of California may be mailed to:

Blue Shield of California

601 12th Street

Oakland, CA 94607

Identification Cards

Identification cards will be issued by Blue Shield of California to all Subscribers.

Possession of a Blue Shield of California identification card confers no right to services or other Benefits of this Agreement. To be entitled to services, the Member must be a Subscriber who has maintained enrollment under the terms of this Agreement.

Dental Customer Service

Questions about services, providers, Benefits, how to use the Plan, or concerns regarding the quality of care or access to care that you have experienced should be directed to your Dental Customer Service at the phone number or address which appear below:

1-888-702-4171

Blue Shield of California

Dental Plan Administrator

425 Market Street, 15th Floor

San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

If the grievance involves a Non-Participating Dentist, the Subscriber should contact the appropriate Blue Shield Customer Service Department shown on the last page of this Evidence of Coverage.

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

Grievance Process

Blue Shield of California has established a grievance procedure for receiving, resolving and tracking Subscribers' grievances.

Subscribers, a designated representative, or a provider on behalf of the Subscriber, may contact the Dental Customer Service Department by telephone, letter or

online to request a review of an initial determination concerning a claim or service. Subscribers may contact the Dental Customer Service Department at the telephone number as noted below. If the telephone inquiry to the Dental Customer Service Department does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Dental Customer Service Representative will initiate on the Subscriber's behalf.

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

1-888-702-4171

Blue Shield of California

Dental Plan Administrator

425 Market Street, 15th Floor

San Francisco, CA 94105

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

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

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at **1-800-424-6521** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in Nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website, **(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.

Continuation of Group Coverage

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

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

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), a Member will be entitled to elect to continue group coverage under this Plan if the Member would otherwise lose coverage because of a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

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

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

Qualifying Event

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

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

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

    a. the death of the Subscriber; or
    b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
    c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
    d. the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership; or
    e. the Subscriber's entitlement to Benefits under Title XVIII of the Social Security Act ("Medicare"); or
    f. a Dependent child's loss of Dependent status under this Plan.
3. For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1. With respect to COBRA enrollees:

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

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

    When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under this Plan. The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

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

2. With respect to Cal-COBRA enrollees:

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

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

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

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

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

Duration and Extension of Continuation of Group Coverage

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

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

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

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

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

Notification Requirements

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

Payment of Dues

Dues for the Member continuing coverage shall be 102 percent of the applicable group Dues rate if the Member is a COBRA enrollee, or 110 percent of the applicable group Dues rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the

Dues for months 19 through 29 shall be 150 percent of the applicable group Dues rate.

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

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

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

Effective Date of the Continuation of Coverage

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

Termination of Continuation of Group Coverage

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

1. discontinuance of this Group Dental Service Contract (if the Employer continues to provide any group benefit plan for Employees, the Member may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required Dues to the COBRA administrator or the Employer or to Blue Shield of California as applicable. Coverage will end as of the end of the period for which Dues were paid;
3. the Member becomes covered under another group health plan that does not include a Pre-existing Condition exclusion or limitation provision that applies to the Member;
4. the Member becomes entitled to Medicare;
5. the Member commits fraud or deception in the use of the services of this Plan.

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

Continuation of Group Coverage for Members on Military Leave

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

Coordination of Benefits

Coordination of benefits is designed to provide maximum coverage for dental bills at the lowest cost by avoiding excessive payments.

When a Member who is covered under the group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the Members of a group are entitled to payment of or reimbursement for dental expenses, such Member will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual cost during any Calendar Year. Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit amount payable by each plan separately.

If the covered Member is also entitled to benefits under any of the conditions as outlined under the "Limitations

for Duplicate Coverage" provision, benefits received under any such condition will not be coordinated with the benefits of the Plan.

The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision it will always provide its benefits first. Otherwise, the plan covering the patient as an Employee will provide its benefits before the plan covering the patient as a Dependent.

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

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

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

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

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

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

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

If the Plan is the primary carrier with respect to a covered Member, then the Plan will provide its benefits without reduction because of benefits available from any other plan, except that Participating Dentists may collect any difference between their Billed Charges and the Plan's payment, from the secondary carrier(s).

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

When the Plan is secondary in the order of payments, and Blue Shield of California and a Dental Plan Administrator are notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, the Plan will pay the benefits that would be due as if it were the primary plan, provided that the covered Member (1) assigns to a Dental Plan Administrator or Blue Shield of California the right to receive benefits from the other plan to the extent of the difference between the benefits which a Dental Plan Administrator or Blue Shield of California actually pays and the amount that a Dental Plan Administrator or Blue Shield of California would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with a Dental Plan Administrator or Blue Shield of California in obtaining payment of benefits from the other plan, and (3) allows Blue Shield of California or a Dental Plan Administrator to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

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

charged from liability under this Plan to the extent of these payments.

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

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

Reimbursement Provisions

Procedure for Filing a Claim

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

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

All claims for reimbursement must be submitted to a Dental Plan Administrator within one (1) year after the month in which the service is rendered. A Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

Maximum Calendar Year Payment

The Maximum Calendar Year Benefit for Covered Services and supplies provided by Participating Dentists and Non-Participating Dentists is specified on the Summary of Benefits. No Benefits in excess of this amount will be provided to or on behalf of any Member.

Non-Assignability

Coverage or any Benefits of the Blue Shield of California dental plans are not assignable without the written consent of Blue Shield of California.

Possession of a Blue Shield of California ID card confers no right to services or other Benefits of the Plan. To be entitled to services, the Member must be a Subscriber or Dependent who has been accepted by the Employer and enrolled by Blue Shield of California and who has maintained enrollment under the terms of the Plan.

The coverage and Benefits of the Blue Shield of California dental plans are assignable to Participating and Non-Participating Dentists.

Claims Review

Blue Shield of California and a Dental Plan Administrator reserve the right to review all claims and services to determine if any exclusion or other limitations apply.

Blue Shield of California or a Dental Plan Administrator may use the services of Dentist consultants, peer review committees of professional societies or hospitals, and other consultants to evaluate claims.

Public Policy Participation Procedure

This procedure enables you to participate in establishing public policy of Blue Shield of California.

It is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

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

At least one third of the Board of Directors of Blue Shield of California is comprised of Subscribers who are not Employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield of California. The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Phone: 1-510-607-2065

Procedure

1. Your recommendations, suggestions or comments should be submitted in writing to the Sr. Manager,

Regulatory Filings, at the above address, who will acknowledge receipt of your letter.

2. Your name, address, phone number, Subscriber number, and group number should be included with each communication.
3. The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter.
4. Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within ten business days after the minutes have been approved.

Grace Period

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

Right of Recovery

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

Confidentiality of Personal and Health Information

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

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

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

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

Correspondence Address:
Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540
Toll-Free Telephone:
1-888-266-8080
Email Address:
blueshieldca_privacy@blueshieldca.com

Notice about Confidential Communication Requests

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

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

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

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

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

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

Once in place, a valid confidential communication request prevents Blue Shield from: 1. Requiring the protected individual to obtain the primary Subscriber's or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care; and 2. Disclosing medical information relating to sensitive health services provided to a protected individual to the primary Subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

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

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

Email: [privacy@blueshieldca.com]

Fax: [1-800-201-9020]

Access to Information

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

Independent Contractors

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

Definitions

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

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

Allowable Amount - 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.

Annual Account Reward - the rewards amount earned during the Calendar Year, not to exceed the Annual Claim Threshold. Annual Account Rewards does not include Annual Network Reward.

Annual Claim Threshold - to earn rewards under Blue Shield Life's Dental Smile Rollover Rewards, the claim(s) submitted by the Member during the Calendar Year cannot exceed this amount.

Annual Network Reward - reward amount earned when all annual claims are for services rendered by Participating Dentists during the Calendar Year.

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

Billed Charges - the prevailing rates of the dental office.

Calendar Year - a period beginning on January 1 of any year and terminating on January 1 of the following year.

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

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

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

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

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 Plan Administrator (DPA) - Blue Shield has contracted with a Dental Plan Administrators (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 licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

Dependent -

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

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

   or,
3. a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner. 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 who is less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by Blue Shield of California as a Dependent and has maintained membership in accordance with the Contract.

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

4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:
   a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
   b. the Subscriber, spouse, or Domestic Partner submits to Blue Shield a Physician's written

certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and

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

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

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

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

1. Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;
2. The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
3. The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
4. Both partners are capable of consenting to the domestic partnership; and
5. The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this Plan. If permitted by your Employer, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code).

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

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

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

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

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

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

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

or other studies on human patients, shall be considered Experimental or Investigational in Nature.

Family - the Subscriber and all enrolled Dependents.

Group Dental Service Contract (Contract) - the Contract issued by the Plan to the Contractholder that establishes the services that Subscribers and Dependents are entitled to receive from the Plan.

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

Initial Maximum Calendar Year Benefit - this is the maximum amount the Plan pays annually for Covered Services and supplies provided to the Member, as listed above (does not include the Total Reward Account Maximum amount).

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 Doctor of Dental Surgery or Doctor of Dental Medicine who has not signed a service contract with a Dental Plan Administrator to provide dental services to Subscribers.

Open Enrollment Period - that period of time set forth in the Contract during which eligible Employees and their Dependents may transfer from another health benefit plan sponsored by the Employer to this Plan.

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

Participating Dentist - a Doctor of Dental Surgery or Doctor of Dental Medicine who has signed a service contract with a Dental Plan Administrator to provide dental services to Subscribers.

Periodontics - treatment of gums, tissue and bone that supports the teeth.

Plan - the Blue Shield of California Dental PPO Plan and/or Blue Shield of California.

Potential Maximum Calendar Year Benefit (including Total Reward Account Maximum amount) - this is the potential maximum amount the Plan would pay for Covered Services and supplies provided to the Member in one Calendar Year once the Member earns a Total Reward Account Maximum. This amount is the sum of the Initial Maximum Calendar Year Benefit and the Total Reward Account Maximum amount.

Subscriber - an Employee as defined, who has been enrolled and accepted by Blue Shield of California as a Member of the group Contract and has maintained his or her Blue Shield of California coverage under the terms of this group Contract.

Total Rewards - this equals Annual Rewards + Annual Network Reward and is the highest rewards amount a Member can earn during the Calendar Year.

Total Reward Account Maximum - this is the limit on the rewards amount a Member can accumulate. After reaching this limit, no additional rewards can be earned regardless of plan year claims.

Customer Service

1-888-702-4171

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

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

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

Please direct correspondence to:

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

Si desea recibir este Aviso Sobre Practicas de Privacidad en español, por favor llame a Servicios a Clientes en el numero que se encuentra en su tarjeta de identificación de Blue Shield.

Notice of privacy practices

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

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

Our privacy commitment

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

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

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

How we protect your privacy

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

Workforce members are trained on topics including:

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

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

How we use and disclose your PHI

Uses of PHI without your authorization. We may disclose your PHI without your written authorization if necessary while providing health benefits and services

to you. We may disclose your PHI for the following purposes:

- **Treatment:**
  - To share with nurses, doctors, pharmacists, optometrists, health educators, and other healthcare professionals so they can determine your plan of care.
  - To help you obtain services and treatment you may need – for example, ordering lab tests and using the results.
  - To coordinate your health care and related services with a healthcare facility or professional.
- **Payment:**
  - To obtain payment of premiums for your coverage.
  - To make coverage determinations – for example, to speak to a healthcare professional about payment for services provided to you.
  - To coordinate benefits with other coverage you may have – for example, to speak to another health plan or insurer to determine your eligibility or coverage.
  - To obtain payment from a third party that may be responsible for payment, such as a family member.
  - To otherwise determine and fulfill our responsibility to provide your health benefits – for example, to administer claims.
- **Healthcare operations:**
  - To provide customer service.
  - To support and/or improve the programs or services we offer you.
  - To assist you in managing your health – for example, to provide you with information about treatment alternatives you may be entitled to, or to provide you with healthcare service or treatment reminders.
  - To support another health plan, insurer, or healthcare professional who has a relationship with you, to improve the programs it offers you – for example, for case management or in support of an accountable care organization (ACO) or patient-centered medical home arrangement.
  - For underwriting, dues, or premium rating, or other activities relating to the creation, renewal, or replacement of a contract for health coverage or insurance. Please note, however, that we will not use or disclose your PHI that is genetic information for underwriting purposes – doing so is prohibited by federal law.

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

- **Disclosures to others involved in your health care.**
  - If you are present or otherwise available to direct us to do so, we may disclose your PHI to others, for example, a family member, a close friend, or your caregiver.
  - If you are in an emergency situation, are not present, are incapacitated, or if you are deceased, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interest. If we do disclose your PHI in a situation where you are unavailable, we will disclose only information that is directly relevant to the person's involvement

with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, your general medical condition, or your death.

  - We may disclose your minor child's PHI to the child's other parent.

- **Disclosures to your plan sponsor.** We may disclose PHI to the sponsor of your group health plan, which may be your employer, or to a company acting on behalf of the plan sponsor, so that they can monitor, audit, and otherwise administer the health plan you participate in. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your plan sponsor's plan documents for information about whether your employer/plan sponsor receives PHI, and for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI.
- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:
  - Companies that perform certain services on behalf of Blue Shield. For example, we may engage vendors to help us provide information and guidance to members with chronic conditions like diabetes and asthma.
  - Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

    Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.
- **Communications.** We may use your PHI to contact you with information about your Blue Shield health plan coverage, benefits, health-related programs and services, treatment reminders, or treatment alternatives available to you. We do not use your PHI for fundraising purposes.
- **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of the general public.
- **Public health activities.** We may disclose your PHI to:
  - Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations.
  - Report child abuse or neglect, or adult abuse, including domestic violence, to a government authority authorized by law to receive such reports.
  - Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety, or effectiveness of the product or activity.
  - Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give such a notice.
- **Health oversight activities.** We may disclose your PHI to:
  - A government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid.

  - Other regulatory programs that need health information to determine compliance.
- **Research.** We may disclose your PHI for research purposes, but only according to, and as allowed by, law.
- **Compliance with the law.** We may use and disclose your PHI to comply with the law.
- **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
- **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Government functions.** We may disclose your PHI to various departments of the government, such as the U.S. military or the U.S. Department of State, as required by law.
- **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws.

Uses of PHI that require your authorization. Other than for the purposes described above, we must obtain your written authorization to use or disclose your PHI. For example, we will not use your PHI for marketing purposes without your prior written authorization, nor will we give your PHI to a prospective employer without your written authorization.

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

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

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

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

Your individual rights

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

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

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

- **Right to receive confidential communications.** You may ask to receive Blue Shield communications containing PHI by alternative means or at alternative locations. As required by law, and whenever feasible, we will accommodate reasonable requests. We may require that you make your request in writing. If your request involves a minor child, we may ask you to provide legal documentation to support your request.
- **Right to access your PHI.** You may ask to inspect or to receive a copy of certain PHI that we maintain about you in a "designated record set." This includes, for example, records of enrollment, payment, claims adjudication, and case or medical management record systems, and any information we used to make decisions about you. Your request must be in writing. Whenever possible, and as required by law, we will provide you with a copy of your PHI in the form (paper or electronic) and format you request. If you request a copy of your PHI, we may charge you a reasonable, cost-based fee for preparing, copying, and/or mailing it to you. In certain limited circumstances permitted by law, we may deny you access to a portion of your records.
- **Right to amend your records.** You have the right to ask us to correct or amend the PHI that we maintain about you in a designated record set. Your request must be made in writing and explain why you want your PHI amended. If we determine that the PHI is inaccurate or incomplete, we will correct it if permitted by law. If a doctor or healthcare facility created the PHI that you want to change, you should ask them to amend the information.
- **Right to receive an accounting of disclosures.** Upon your written request, we will provide you with a list of the disclosures we have made of your PHI for a specified time period, up to six years prior to the date of your request. However, the list will exclude:
  - Disclosures you have authorized.
  - Disclosures made earlier than six years before the date of your request.
  - Disclosures made for treatment, payment, and healthcare operations purposes, except when required by law.
  - Certain other disclosures that we are allowed by law to exclude from the accounting.

  If you request an accounting more than once during any 12-month period, we will charge you a reasonable, cost-based fee for each accounting report after the first one.
- **Right to name a personal representative.** You may name another person to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the healthcare professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make healthcare decisions for you.
- **Right to receive a paper copy of this Notice.** Upon your request, we will provide a paper copy of this Notice, even if you have agreed to receive the Notice electronically. See the "Notice Availability and Duration" section of this Notice.

Actions you may take

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

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

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

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

Email: privacy@blueshieldca.com

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

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

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

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

Region IX Regional Manager
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th St., Suite 4-100
San Francisco, CA 94103

Phone: (800) 368-1019

Fax: (202) 619-3818

TTY: (800) 537-7697

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

Notice availability and duration

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

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

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

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

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)**。