Dental PPO Plan

Evidence of Coverage and Health Service Agreement

Individual and Family Plans

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Blue Shield of California
Individual and Family
Dental PPO Plan

EVIDENCE OF COVERAGE AND
HEALTH SERVICE AGREEMENT

This AGREEMENT is issued by California Physicians' Service d/b/a Blue Shield of California ("Blue Shield"), a not for profit health care service Plan, to the Subscriber whose identification cards are issued with this Agreement. In consideration of statements made in the application and timely payment of Dues, Blue Shield of California agrees to provide the benefits of this Agreement.

NOTICE TO NEW SUBSCRIBERS

Please read this Service Agreement carefully. If you have any questions, contact Blue Shield. You may surrender this Agreement by delivering or mailing it with the identification cards, within ten (10) days from the date it is received by you, to BLUE SHIELD OF CALIFORNIA, 50 BEALE STREET, SAN FRANCISCO, CALIFORNIA 94105. Immediately upon such delivery or mailing, the Agreement shall be deemed void from the beginning, and Dues paid will be refunded.

IMPORTANT!

No Person has the right to receive the benefits of this plan for Services or supplies furnished following termination of coverage. Benefits of this plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming benefits is actually covered by this Agreement 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 the modification. There is no vested right to receive the benefits of this Agreement.

IMPORTANT!

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

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Summary of Benefits and Member Copayments

The following chart outlines specific Dental procedures covered by the Plan and the Member's Copayment Responsibility for those procedures. Services are listed with the American Dental Association (ADA) procedure code.

For dental Services received from a Participating Dentist, the Member will be responsible for the amount indicated under the In-Network column.

For dental Services received from a Non-Participating Dentist, the Plan will reimburse the Member up to the maximum amount listed under the Out-of-Network column, and the Member will be responsible for the remainder of the Dentist's Billed Charges.

ADA CODE	PROCEDURE	In Network Member Pays:	Out of Network Max. Plan Payment:
	Diagnostic (exams and x-rays)		
D0120	Periodic oral evaluation	You pay nothing	$16
D0140	Limited oral evaluation-problem focused	You pay nothing	$24
D0150	Comprehensive oral evaluation	You pay nothing	$40
D0210	Intraoral radiographs - complete series (including bitewings) (once every 36 months)	You pay nothing	$56
D0220	Intraoral periapical radiograph - first film	You pay nothing	$16
D0230	Intraoral periapical radiograph - each additional film	You pay nothing	$8
D0240	Intraoral occlusal radiograph	You pay nothing	$28
D0270	Bitewing radiograph - single film	You pay nothing	$14
D0272	Bitewing radiograph - two films	You pay nothing	$20
D0274	Bitewing radiograph - four films	You pay nothing	$24
D0330	Panoramic film (once every 36 months)	You pay nothing	$40
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	You pay nothing	$25
D0460	Pulp vitality tests	You pay nothing	$18
D0470	Diagnostic casts	You pay nothing	$40
D9310	Specialist - consultation (as necessary)	$30	$24

ADA CODE	PROCEDURE	In Network Member Pays:	Out of Network Max. Plan Payment:
	Preventive (cleanings and fluoride)		
D1110	Prophylaxis (adult) every 6 months	You pay nothing	$48
D1120	Prophylaxis (child) every 6 months	You pay nothing	$34
D1203	Topical application of fluoride - child (covered through age 15)	You pay nothing	$15
D1206	Topical fluoride varnish (covered through age 15)	You pay nothing	$19
D1351	Sealant per tooth (covered through age 15)	You pay nothing	$22
D1510	Space maintainer - fixed - unilateral	You pay nothing	$148
D1515	Space maintainer - fixed - bilateral	You pay nothing	$228
D1520	Space maintainer - removable - unilateral	You pay nothing	$200
D1525	Space maintainer - removable - bilateral	You pay nothing	$228
D1550	Recementation of space maintainer	You pay nothing	$25
D1555	Removal of fixed space maintainer	You pay nothing	$25
	Minor restorative (fillings) **There is a 3 month waiting period for these procedures.**		
D2140	Amalgam one surface, primary or permanent	$35	$28
D2150	Amalgam - two surfaces, primary or permanent	$43	$34
D2160	Amalgam three surfaces, primary or permanent	$53	$42
D2161	Amalgam - four surfaces, primary or permanent	$68	$54
D2330	Resin based composite- one surface, anterior	$37	$30
D2331	Resin based composite- two surfaces, anterior	$56	$44
D2332	Resin based composite- three surfaces, anterior	$68	$54
D2335	Resin based composite- four or more surfaces or involving incisal angle, anterior	$68	$54
	Major restorative (crowns) **There is a 12 month waiting period for these procedures.**		
D2542	Onlay metallic – two surfaces	$142	$112
D2543	Onlay metallic – three surfaces	$158	$124
D2544	Onlay metallic – four or more surfaces	$175	$138

ADA CODE	PROCEDURE	In Network Member Pays:	Out of Network Max. Plan Payment:
D2642	Onlay – porcelain / ceramic – two surfaces	$128	$101
D2643	Onlay – porcelain / ceramic – three surfaces	$150	$118
D2644	Onlay – porcelain / ceramic – four or more surfaces	$165	$130
D2710	Crown – resin-based composite (indirect)	$160	$128
D2712	Crown – ¾ resin-based composite (indirectly)	$160	$160
D2740	Crown – porcelain/ceramic substrate	$265	$212
D2750	Crown – porcelain fused to high noble metal	$320	$256
D2751	Crown – porcelain fused to predominantly base metal	$315	$252
D2752	Crown – porcelain fused to noble metal	$320	$256
D2780	Crown – ¾ cast high noble metal	$298	$238
D2781	Crown – ¾ cast predominantly base metal	$298	$238
D2782	Crown – ¾ cast noble metal	$298	$238
D2790	Crown – full cast high noble metal	$320	$256
D2791	Crown – full cast predominantly base metal	$31	$252
D2792	Crown – full cast noble metal	$35	$252
D2794	Crown – titanium	$320	$371
D2910	Recement inlay, onlay or partial coverage restoration	$22	$17
D2915	Recement cast or prefabricated post and core	$22	$22
D2920	Recement crown	$25	$20
D2930	Prefabricated stainless steel crown - primary tooth	$53	$42
D2931	Prefabricated stainless steel crown - permanent tooth	$59	$47
D2932	Prefabricated resin crown	$51	$41
D2934	Prefabricated esthetic coated stainless steel (primary)	$53	$53
D2940	Protective restoration	$21	$16
D2950	Core buildup, including any pins	$54	$43
D2951	Pin retention - per tooth – in addition to restoration	$28	$22
D2952	Post and core in addition to crown, indirectly fabricated	$86	$69
D2953	Each additional indirectly fabricated – same tooth	$43	$33
D2954	Prefabricated post and core in addition to crown	$81	$64
D2957	Each additional prefabricated post – same tooth	$40	$31
D2980	Crown repair, by report	$50	$40
	Periodontics (gum disease) **There is a 3 month waiting period for these procedures.**		
D4210	Gingivectomy / gingivoplasty four or more contiguous teeth or tooth bounded spaces – per quadrant	$161	$128

ADA CODE	PROCEDURE	In Network Member Pays:	Out of Network Max. Plan Payment:
D4211	Gingivectomy / gingivoplasty one to three contiguous teeth or tooth bounded spaces – per quadrant	$59	$46
D4240	Gingival flap procedure including root planing four or more teeth – per quadrant	$115	$92
D4241	Gingival flap procedure including root planing one to three teeth – per quadrant	$69	$54
D4249	Clinical crown lengthening - hard tissue	$138	$110
D4260	Osseous surgery (including flap entry and closures) four or more contiguous teeth or tooth bounded spaces - per quadrant	$263	$210
D4261	Osseous surgery (including flap entry and closures) one to three contiguous teeth or tooth bounded spaces - per quadrant	$158	$124
D4263	Bone replacement graft – first site in quadrant	$160	$128
D4264	Bone replacement graft -each additional site in quadrant	$203	$162
D4266	Guided tissue regeneration – resorbable barrier per site	$240	$192
D4267	Guided tissue regeneration – nonresorbable barrier, per site	$240	$192
D4270	Pedicle soft tissue graft procedure	$132	$105
D4271	Free soft tissue graft procedure (including donor site surgery)	$175	$140
D4273	Subepithelial connective tissue graft procedure per tooth	$259	$207
D4276	Combination connective tissue and double pedicle graft - per tooth	$132	$170
D4341	Periodontal scaling and root planing – four or more teeth - per quadrant	$65	$52
D4342	Periodontal scaling and root planing – one to three teeth - per quadrant	$32	$25
D4355	Full mouth debridement before comprehensive treatment	$53	$42
D4910	Periodontal maintenance	$33	$35
D9951	Occlusal adjustment – limited	$50	$40
D9952	Occlusal adjustment – complete	$200	$160
	Prosthetics removable (dentures) **There is a 12 month waiting period for these procedures.**		
D5110	Complete denture – maxillary	$388	$310
D5120	Complete denture – mandibular	$388	$310
D5130	Immediate denture – maxillary	$388	$310
D5140	Immediate denture – mandibular	$388	$310
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$375	$300
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$375	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$450	$360
D5214	Mandibular partial denture - cast metal framework with denture bases (including any conventional clasps, rests and teeth)	$450	$360
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$450	$495

ADA CODE	PROCEDURE	In Network Member Pays:	Out of Network Max. Plan Payment:
D5226	Mandibular partial denture - flexible base (including clasps, rests and teeth)	$450	$495
D5281	Removable unilateral partial denture, one piece cast metal (including clasps and teeth)	$215	$172
D5410	Adjust complete denture – maxillary	$28	$22
D5411	Adjust complete denture – mandibular	$28	$22
D5421	Adjust partial denture – maxillary	$28	$22
D5422	Adjust partial denture – mandibular	$28	$22
D5510	Denture repair – complete denture, broken base	$53	$42
D5520	Denture repair –missing or broken teeth – complete denture -each tooth	$53	$42
D5610	Denture repair – acrylic saddle or base	$53	$42
D5620	Denture repair – cast framework	$53	$42
D5630	Denture repair – repair or replace clasp	$69	$55
D5640	Denture repair – broken tooth - per tooth	$43	$34
D5650	Add tooth to existing partial denture	$43	$34
D5660	Add clasp to existing partial denture	$75	$60
D5670	Replace all teeth and acrylic on cast framework - maxillary	$236	$186
D5671	Replace all teeth and acrylic on cast framework - mandibular	$236	$186
D5710	Denture rebase - complete maxillary	$140	$112
D5711	Denture rebase - complete mandibular	$140	$112
D5720	Denture rebase partial maxillary	$140	$112
D5721	Denture rebase partial mandibular	$140	$112
D5730	Reline complete maxillary denture – (chairside)	$80	$64
D5731	Reline complete mandibular denture – (chairside)	$80	$64
D5740	Reline maxillary partial denture – (chairside)	$80	$64
D5750	Reline complete maxillary denture – (laboratory)	$135	$108
D5751	Reline complete mandibular denture – (laboratory)	$135	$108
D5760	Reline maxillary partial denture – (laboratory)	$135	$108
D5761	Reline mandibular partial denture – (laboratory)	$135	$108
D5850	Tissue conditioning – maxillary	$33	$26
D5851	Tissue conditioning – mandibular	$33	$26
	Bridge abutment or pontics **There is a 12 month waiting period for these procedures.**		
D6210	Pontic – cast metal	$293	$234
D6211	Pontic – cast predominantly base metal	$293	$234
D6212	Pontic – cast noble metal	$293	$234

ADA CODE	PROCEDURE	In Network Member Pays:	Out of Network Max. Plan Payment:
D6214	Pontic – cast titanium	$293	$293
D6240	Pontic – porcelain fused to high noble metal	$293	$234
D6241	Pontic – porcelain fused to predominantly base metal	$293	$234
D6242	Pontic – porcelain fused to noble metal	$293	$234
D6545	Retainer- cast metal for resin bonded fixed prosthesis	$123	$98
D6608	Onlay – porcelain/ceramic - two surfaces	$128	$101
D6609	Onlay – porcelain/ceramic - three or more surfaces	$150	$118
D6610	Onlay – cast high noble metal - two surfaces	$169	$135
D6611	Onlay – cast high noble metal - three or more surfaces	$185	$148
D6612	Onlay – cast predominately base metal - two surfaces	$145	$116
D6613	Onlay – cast predominately base metal - three or more surfaces	$161	$128
D6614	Onlay – cast noble metal - two surfaces	$153	$122
D6615	Onlay – cast noble metal - three or more surfaces	$169	$135
D6634	Onlay – titanium	$185	$185
D6750	Bridge retainer – crown – porcelain / fused to high noble metal	$313	$250
D6751	Bridge retainer – crown – porcelain / fused to predominantly base metal	$298	$238
D6752	Bridge retainer – crown – porcelain / fused to noble metal	$305	$244
D6780	Bridge retainer - crown – ¾ cast high noble metal	$313	$250
D6781	Bridge retainer - crown – ¾ cast predominately base metal	$313	$250
D6782	Bridge retainer - crown – ¾ cast noble metal	$313	$250
D6790	Bridge retainer – crown – full cast high noble metal	$313	$250
D6791	Bridge retainer – crown – full cast predominantly base metal	$298	$233
D6792	Bridge retainer – crown – full cast noble metal	$305	$244
D6794	Bridge retainer - crown titanium	$313	$378
D6930	Recement fixed partial denture	$38	$30
D6970	Cast post and core in addition to fixed partial denture retainer, indirectly fabricated	$97	$77
D6972	Prefabricated post with core buildup in addition to fixed denture retainer	$87	$69
D6976	Each additional indirectly fabricated post – same tooth	$49	$38
D6977	Each additional prefabricated post – same tooth	$43	$34
	Endodontics (root canals) **There is a 3 month waiting period for these procedures.**		
D3110	Pulp cap (direct) excluding final restoration	$18	$14
D3120	Pulp cap (indirect) excluding final restoration	$26	$21
D3220	Pulpotomy	$33	$26

ADA CODE	PROCEDURE	In Network Member Pays:	Out of Network Max. Plan Payment:
D3310	Root canal therapy – anterior tooth (excluding final restoration)	$156	$125
D3320	Root canal therapy – bicuspid tooth (excluding final restoration)	$188	$150
D3330	Root canal therapy – molar (excluding final restoration	$234	$187
D3346	Retreatment of previous root canal – anterior	$156	$145
D3347	Retreatment of previous root canal – bicuspid	$188	$180
D3348	Retreatment of previous root canal – molar	$234	$227
D3351	Apexification / recalcification (initial visit)	$73	$58
D3352	Apexification / recalcification (interim visit)	$73	$58
D3353	Apexification / recalcification (final visit)	$73	$58
D3410	Apioectomy / periradicular surgery – anterior	$200	$160
D3421	Apioectomy / periradicular surgery – bicuspid, first root	$200	$160
D3425	Apioectomy / periradicular surgery – molar, first root	$218	$174
D3426	Apioectomy / periradicular surgery – molar, each additional root	$100	$80
D3430	Retrograde filling – per root	$101	$80
D3450	Root amputation – per root	$71	$56
D3920	Hemisection (including any root removal; not including root canal therapy)	$100	$80
	Oral surgery (extractions) **There is a 3 month waiting period for these procedures.**		
D7111	Extraction of coronal remnants – deciduous tooth	$20	$16
D7140	Extraction of erupted tooth or exposed root	$40	$32
D7210	Surgical removal of erupted tooth	$63	$50
D7220	Removal of impacted tooth - soft tissue	$68	$54
D7230	Removal of impacted tooth - partial bony	$104	$83
D7240	Removal of impacted tooth - complete bony with unusual surgical complications	$113	$90
D7250	Surgical removal of residual tooth roots	$55	$44
D7260	Oroantral fistula closure	$70	$56
D7286	Biopsy of oral tissue – soft [1]	$63	$50
D7287	Exfoliative cytological sample collection	$38	$30
D7288	Brush biopsy transepithelial sample collection	$32	$44
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$57	$46
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$63	$50
D7471	Removal of lateral exostosis maxilla or mandible	$88	$70
D7472	Removal of torus palatinus	$88	$70

ADA CODE	PROCEDURE	In Network Member Pays:	Out of Network Max. Plan Payment:
D7473	Removal of torus mandibularis	$88	$70
D7510	Incision & drainage of abscess – intraoral soft tissue	$38	$30
D7511	Incision & drainage of abscess – intraoral soft tissue -complicated (includes drainage of multiple facial spaces)	$48	$65
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$100	$80
D7960	Frenectomy / Frenotomy – separate procedure	$88	$70
D7963	Frenuloplasty	$88	$122
D7970	Excision of hyperplastic tissue – per arch [1]	$100	$80
D7971	Excision of pericoronal gingival [1]	$43	$34
	Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure [3]	$25	$20
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	You pay nothing	$0
D9215	Local anesthesia in conjunction with outpatient surgical procedures	You pay nothing	$0
D9220	General anesthesia – first 30 minutes	$23	$58
D9221	General anesthesia – each additional 15 minutes	$30	$24
D9241	IV sedation – first 30 minutes	$98	$78
D9242	IV sedation – each additional 15 minutes	$30	$24
D9910	Application of desensitizing medicament	$10	$8
	Other		
	Sterilization surcharge [2]	You pay nothing	No Benefit
	Orthodontics[4,5,6] Orthodontic treatment to correct malocclusion, limited to one continuous two-year course of treatment. There is a 12-month waiting period for these procedures.		
D8080	Comprehensive orthodontic treatment of the transitional dentition	$2,350	Not covered
D8090	Comprehensive orthodontic treatment of the adolescent dentition	$2,650	Not covered
D9940	Occlusal guards, by report	$113	$90
D9942	Repair and/or reline of occlusal guard	$34	$34

Footnotes

[1] The Subscriber pays lab fees for biopsies and excisions.

[2] No benefits are provided if these covered Services are performed by a Non-Participating dentist.

[3] For an emergency oral exam with palliative treatment, if treatment includes a listed procedure, then regular Copayment applies.

[4] In order to be covered, orthodontic treatment must be received in one continuous course of treatment; must be received in consecutive months; and must not exceed 24 consecutive months.

[5] Full case fee includes consultation, treatment plan, tooth movement, and retention. Orthodontist may charge Members separately for records, limited to $250 per case.

[6] The orthodontic benefit is subject to all Plan limitations.

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 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 a contracted 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 contracted Dental Plan Administrator at 1-888-679-8928. You may also access a list of Participating Dentists through Blue Shield of California's internet site located at http://www.blueshieldca.com. You are also responsible for following the Pre-certification of Dental Benefits Program that includes obtaining or assuring that the Dentist obtains Pre-certification of Benefits.

NOTE: A contracted Dental Plan Administrator will respond to all requests for pre-certification 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 contracted 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 Pre-certification process both you and the Dentist will know in advance which services are covered and the benefits that are payable.

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 contracted Dental Plan Administrator's payment, plus your payment of any applicable deductible and copayment, as payment in full for covered services. This is not true of Non-Participating Dentists.

If you go to a Non-Participating Dentist, you will be reimbursed up to a pre-determined maximum amount, for covered services. Your reimbursement may be substantially less than the billed amount. 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 Providers submit claims for payment after their services have been rendered. These payments go directly to the Participating Provider. You or your Non-Participating Providers submit claims for reimbursement after services have been rendered. If you receive services from Non-Participating Providers, you have the option of having payments sent directly to the Non-Participating Provider or sent directly to you. A contracted Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

Providers do not receive financial incentives or bonuses from Blue Shield of California.

You may access a Directory of Participating Dentists through Blue Shield of California's Internet site located at http://www.blueshieldca.com. The names of Participating Dentists in your area may also be obtained by contacting a contracted Dental Plan Administrator at 1-888-679-8928.

Continuity of Care by a Terminated Provider

Persons 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 contracted 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.

Conditions of Coverage

Eligibility and Enrollment

1. To enroll and continue enrollment, a Member must meet all of the eligibility requirements of the Plan.
2. Enrollment of Subscribers or Dependents is not effective until Blue Shield of California approves an application and accepts the applicable Dues. Applications can only be approved by Blue Shield of California's Underwriting Department.
3. An applicant, upon completion and approval by Blue Shield of California of the application, is entitled to the benefits of this Agreement upon the Effective Date.
4. The Effective Date of the benefits of a newborn child will be the date of birth if the Subscriber contacts Blue Shield of California at the Customer Service telephone number

listed at the back of this booklet, to have the newborn child added to this Agreement as a Dependent. Such request must be made within 31 days of the newborn child's date of birth. If a request to add the child as a Dependent is not made within 31 days of birth, the coverage for that child shall terminate on the 31st day at 11:59 p.m. Pacific Time.

If the Subscriber wishes to add a newborn child as a Dependent 32 or more days after birth, coverage will not be retroactive and there will be a gap in coverage. See Paragraph 6 below.

5. The Effective Date of benefits for an adopted child will be the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, if the Subscriber requests the child be added to this Agreement as a Dependent. Such request must be made within 31 days of the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, the coverage for that child shall terminate on the 31st day at 11:59 p.m. Pacific Time.

   To add a child placed for adoption to this Agreement as a Dependent, the Subscriber must contact Blue Shield of California at the Customer Service telephone number listed at the back of this booklet. The Customer Service Department will advise the Subscriber of the exact process for adding a child placed for adoption as a Dependent, including, but not limited to, the necessary documentation and how the documentation shall be submitted to Blue Shield of California.

   Enrollment requests for an adopted child must be accompanied by evidence of the Subscriber's or spouse's right to control the child's health care, which includes a facility minor release report, a medical authorization form, or a relinquishment form.

   If the Subscriber wishes to add a child placed for adoption as a Dependent 32 or more days after the date the Subscriber, spouse, or Domestic partner has the right to control the child's health care, coverage will not be retroactive and there will be a gap in coverage. See Paragraph 6 below.

6. If a court has ordered that you provide coverage for your spouse or Domestic Partner under you health benefit plan, their coverage will become effective within 31 days of presentation of a court order.

7. The Member can also add a Dependent under the age 19 as long as they apply during a period no longer than 63 days after any event listed below:

   a. Losing Dependent coverage due to:

      (i) The termination or change in employment status of this Dependent or the person through whom this Dependent was covered; or

      (ii) The cessation of an employer's contribution toward an employee or Dependent's coverage; or

      (iii) The death of the person through whom this Dependent was covered as a Dependent; or

      (iv) Legal separation or divorce; or

   b. Loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program or the Medi-Cal Program;

   c. Adoption of the child; or

   d. The child became a resident of California during a month that was not the child's birth month; or

   e. The child is born as a resident of California and did not enroll in the month of birth; or

   f. The child is mandated to be covered pursuant to a valid state or federal court order (presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, of Section 3751.5 of the Family Code.

Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the Dues for the same coverage may be higher than the Dues you pay now.

Limitation of Enrollment

1. Subscribers must be Residents of California. Upon change of residence outside of California, the Blue Shield of California Individual and Family Dental PPO Plan will terminate.

2. Dependent benefits shall be discontinued as of the following, except as specifically set forth in the definition of Dependent in the section entitled Definitions:

   a. The date the Dependent child attains age 26; or

   b. The date the Dependent spouse or Domestic Partner enters a final decree of divorce, annulment, or dissolution of marriage, or termination of domestic partnership from the Subscriber.

3. If the Subscriber seeks to add a Dependent under age 19 to the Plan other than a Dependent described in the paragraphs 3., 4., 5. or 6. of the section entitled Eligibility and Enrollment, this will result in Blue Shield of California recalculating or reassigning the appropriate Dues based on underwriting review of the Dependent.

4. If a Member commits any of the following acts, they will immediately lose eligibility to continue enrollment:

   a. Abusive or disruptive behavior which:

      (1) Threatens the life or well being of Blue Shield of California personnel and providers of Services;

      (2) Substantially impairs the ability of Blue Shield of California to arrange for Services to the Person; or

(3) Substantially impairs the ability of providers of Service to furnish Services to the Person or to other patients;

b. Failure or refusal to provide Blue Shield of California access to documents and other information necessary to determine eligibility or to administer benefits under the Plan.

Duration of the Agreement

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

Termination / Reinstatement of the Agreement

This Agreement may be rescinded or terminated as follows:

1. Termination by the Subscriber:

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

2. Termination by Blue Shield of California through cancellation:

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

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

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

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

3. Termination by Blue Shield of California if Subscriber moves out of service area:

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

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

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

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

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

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

   Within five (5) business days of canceling or not renewing the Agreement, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

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

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

7. Reinstatement of the Agreement after Termination for Non-Payment:

   If the Agreement is cancelled for nonpayment of Dues, Blue Shield of California will permit reinstatement of the Agreement or coverage twice

during any twelve-month period, without a change in Dues and without consideration of the medical condition of you or any Dependent, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Agreement is cancelled for nonpayment of Dues more than twice during the preceding twelve-month period, then Blue Shield of California is not required to reinstate you, and you will need to re-apply for coverage. In this case, Blue Shield of California may impose different Dues and consider the medical condition of you and your Dependents.

Pre-certification of Dental Benefits

Before any course of treatment expected to cost more than $250 is started, you should obtain Pre-certification of Benefits. Your Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic X-rays to a contracted Dental Plan Administrator. A contracted 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 contracted Dental Plan Administrator for payment determination. A contracted 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, this plan will in most cases provide benefits based on the most cost-effective procedure. The benefits provided under this plan are based on these considerations but you and your Dentist make the final decision regarding treatment.

Failure to obtain Pre-certification of Benefits may result in a denial of benefits. If the Pre-certification process is not followed, a contracted 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 Pre-certification 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 contracted Dental Plan Administrator. If you and your Dentist decide on a more costly procedure, service or material than a contracted 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 contracted Dental Plan Administrator reserves the right to use the services of dental consultants in the Pre-certification review.

Example:

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

Payment and Subscriber Copayment Responsibilities

Participating Dentists

PLEASE READ THE FOLLOWING SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS, HEALTH CARE MAY BE PROVIDED.

When you receive covered dental services from a Participating Dentist, you will be responsible for a fixed copayment as outlined in the section entitled Summary of Benefits and Member Copayments. Participating Dentists will file claims on your behalf.

Services rendered for Diagnostic and Preventive Care will be paid at 100%, subject to certain limitations as specified in the section entitled Covered Services and Supplies.

Participating Dentists will be paid directly by the plan, and have agreed to accept a contracted Dental Plan Administrator's payment, plus your payment of any applicable deductible or copayment, as payment in full for covered services.

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 contracted Dental Plan Administrator as payment in full, but may collect from the covered Member the difference, if any, between the fees paid by a contracted Dental Plan Administrator and the amount collected by the covered Member for these services.

Non-Participating Dentists

When you receive covered services from a Non-Participating Dentist, you will be reimbursed up to a specified maximum amount as outlined in the section entitled Summary of Benefits and Member Copayments. You will be responsible for the remainder of the Dentist's billed charges. You should discuss this beforehand with your Dentist if he is not a Participating Dentist. Any difference between a contracted Dental Plan Administrator's or Blue Shield of California's payment and the Non-Participating Dentist's charges are your responsibility.

Members are expected to follow the billing procedures of the dental office.

If your receive covered Services from a Non-Participating Dentist, either you or your provider may file a claim using the dental claim form which may be obtained by calling Dental Member Services at:

1-888-679-8928

Only claims for benefits for Enhanced Dental Services for Pregnant Women rendered by Non-Participating Dentists should be sent to:

Blue Shield of California
Dental Plan Administrator
Periodontal Coverage for Women during Pregnancy
425 Market Street, 12th. Floor
San Francisco, CA 94105

Claims for all other covered Services rendered by Non-Participating Dentists, should be sent to:

Blue Shield of California
Dental Plan Administrator
P O Box 272590
Chico, CA 95927-2590

Calendar Year Deductible $50 per Member

Except as noted, the $50 Calendar Year deductible applies to all covered Services and supplies furnished by Participating and Non-Participating Dentists [1]. It is the amount that you must pay out of pocket before benefits will be provided for covered Services. This deductible applies separately to each covered Member each calendar year.

1 The Calendar Year deductible does not apply to those dental Services considered by Blue Shield of California to be Diagnostic or Preventive. Please see the Summary of Benefits for additional information.

Reimbursement Provisions

Procedure for Filing a Claim

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

A contracted Dental Plan Administrator will provide payment in accordance with the provisions of this Agreement. You will receive an explanation of benefits after the claim has been processed.

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

Calendar Year Maximum Payment

Your Plan pays up to a maximum of $1,000 per Member each Calendar Year for covered Services and supplies provided by Participating Dentists.

Your Plan pays a maximum of $500 per Member for covered Services and supplies provided by Non-Participating Dentists.

The maximum payment each Calendar Year for covered Services by any combination of Participating and Non-Participating Dentists is $1,000. No benefits in excess of this amount will be provided to or on behalf of any Member.

Covered Services and Supplies

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

The following services are benefits when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice.

These benefits are subject to the general limitations and exclusions of the plan. Payments are subject to the dental benefit deductible and to the copayment amounts indicated in the section entitled Summary of Benefits and Member Copayments.

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 $50 Calendar Year deductible.

Enhanced Dental Benefits for Pregnant Women

This Plan provides additional or enhanced benefits for certain services for women who are pregnant. When the benefits below are available, they are not subject to the Calendar Year Deductible.

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

1 If these Services are required outside of pregnancy, coverage is available under the section entitled Endodontics, Oral Surgery, Periodontics, and Restorative Services

Basic Services

Endodontics, Oral Surgery, Periodontics and Restorative Services

These Services are covered after three (3) months of continuous coverage under the plan.

Refer to the section entitled Summary of Benefits and Member Copayments for fixed copayments and maximum reimbursement amounts.

Anesthesia — General, intravenous, or inhalation sedation is only a covered benefit when provided in conjunction with a covered oral surgical procedure. See General Limitations and Exclusions section for more details.

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).

Oral Surgery — Extractions; removal of impacted teeth, radical excision of small (to 1.25 cm) non-malignant lesions; other surgical procedures; includes local anesthesia and routine pre and postoperative care.

Palliative — Emergency treatment for relief of pain.

Periodontics — Emergency treatment including but not limited to periodontal abscess and acute periodontitis; root planing (not prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post-surgical visits; Amalgam restorations; synthetic restorations (i.e. silicate cement filling, porcelain filling, plastic filling and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material. Onlays, crowns (other than stainless steel); veneers and other laboratory produced restorations and bridges are excluded.

Major Services

These Services are covered after twelve months of continuous coverage under the plan.

Refer to the section entitled Summary of Benefits and Member Copayments for fixed copayments and maximum reimbursement amounts.

Prosthetics — Bridges, dentures, partials and relining or rebasing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stayplate, and special tissue conditioning per denture . No replacement of complete or partial dentures, fixed bridgework or crowns previously covered by the Plan due to loss or theft within sixty (60) months after initial or supplemental placement. This also applies to the damage of any prostheses that is not directly related to faulty lab work. "Prostheses" include retainers, habit appliances and any fixed or removable interceptive orthodontic appliances as well as fixed and removable bridgework.

No replacement of dentures (complete or partial), crowns or fixed bridgework due to provider error. The provider is financially responsible for comparable replacement. If replacement is warranted because of an action by, or the non-compliance of, the patient, that patient is financially liable for replacement of the prosthesis (this includes decay or periodontal disease directly related to patient non-compliance). The Plan will pay for a replacement in this instance after the sixty (60) months waiting period from initial placement has elapsed.

Denture relines (either complete or partial conventional dentures) within six (6) months after insertion of the prosthesis. This service is covered once every twelve months following initial insertion or reline. In the case of immediate full or partial dentures, the final reline must be performed no sooner than eight weeks after tooth extractions and denture insertion. Chair-side tissue conditioners can be used for temporary relief of discomfort and/or to increase retention and be considered palliative treatment. Relines for immediate full and partial dentures will not be covered within two (2) weeks of tooth extraction and prosthesis insertion. One reline for each prosthesis is included in the immediate denture fee between two (2) and six (6) months following insertion.

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); post and cores; crown buildups (on vital or non-vital teeth when functionally necessary). There is no coverage for replacement of an existing crown, onlay, or other cast restoration which is less than five (5) years old. Repair or re-cementing of onlays and crowns, is covered for six (6) months after installation.

Orthodontics — Dental Care Services specifically related to necessary services for the treatment for malocclusion and the proper alignment of teeth are covered, if rendered by a Participating Dental Provider. Orthodontic treatment is limited to one full case during the lifetime of the Member and consists of 24 continuous months of usual and customary Orthodontic care.

The Member must remain eligible throughout the entire course of treatment to receive the full benefit.

General Exclusions and Limitations

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. Dental services not appearing on the Summary of Benefits;
2. Charges for services in connection with any treatment to the gums for tumors, cysts and neoplasms;

3. Charges for implants or the removal of implants (surgically or otherwise) and any appliances and/or crown attached to implants;
4. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers compensation law, occupational disease law or similar legislation. However, if a contracted Dental Plan Administrator or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by a contracted Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;
5. 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 syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint ;
6. Charges for services performed by a close relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
7. 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);
8. All prescription and non-prescription drugs;
9. 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;
10. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;
11. Procedures which are principally cosmetic in nature, including, but not limited to, bleaching, veneer facings, crowns, personalization or characterization of crowns, bridges and/or dentures;
12. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been either lost or stolen within five (5) years of its installation;
13. Myofunctional therapy; biofeedback procedures; athletic mouth-guards; precision or semi-precision attachments; denture duplication; treatment of jaw fractures;
14. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw; charges for services in connection with orthodontia;
15. Alloplastic bone grafting materials;
16. Bone grafting done for socket preservation after tooth extraction;
17. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
18. Any procedure not performed in a dental office setting;
19. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
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 contracted 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 restoration;
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 dental necessity.

    General anesthesia is considered Dentally Necessary when its use is:

    a) In accordance with generally accepted professional standards; and

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

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

    Patient apprehension or patient anxiety will not constitute Dental Necessity.

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

31. Removal of 3rd molar (wisdom) teeth other than for Dental Necessity. Dental Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not dental 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. For services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein; and
34. 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.

Orthodontic Limitations & Exclusions

1. Charges for services in connection with orthodontia when rendered by a Non-Participating Provider;
2. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
3. Treatment in progress (after banding) at inception of eligibility;
4. Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment;
5. Treatment for myofunctional therapy;
6. Changes in treatment necessitated by an accident;
7. Treatment for TMJ (Temporomandibular Joint) disorder or dysfunction;

8. Special orthodontic appliances, including but not limited to invisalign, lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
9. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
10. Treatment exceeding twenty-four (24) months;
11. In the event of a Member's loss of coverage for any reason, if at the time of loss of coverage the Member is still receiving Orthodontic treatment during the 24 month treatment period, the Member and not a contracted Dental Plan Administrator will be responsible for the remainder of the cost for that treatment, at the participating Orthodontist's Billed Charges, prorated for the number of months remaining;
12. If the Member is reinstated after Cancellation, there are no Orthodontic benefits for treatment begun prior to his or her reinstatement effective date:
13. There is a twelve (12) month waiting period before beginning orthodontic treatment.

Dental Necessity Exclusion

All services must be of Dental Necessity. The fact that a dentist or other plan Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Dental necessity.

Alternate Benefits 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 contracted 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;
    b) Routine prophylaxis;
    c) Fluoride treatment;
    d) Bitewing x-rays, maximum for (4) per occurrence; and
    e) Recementations if the crown 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 months;
2. One (1) in twelve (12) month period:
    a) Denture (complete and partial) relines; and
    b) Oral cancer screening;
3. One in twenty-four (24) months:
    a) Full mouth debridement;
    b) Sealants;
    c) Occlusal guards;
4. One (1) in a thirty-six month period:
    a) Mucogingival surgery per area;
    b) Osseous surgery per quad;
    c) Gingival flap surgery per quad;
    d) Gingivectomy per quad;
    e) Gingivectomy per tooth;
    f) Bone replacement grafts for periodontal purposes;
    g) Guided tissue regeneration for periodontal purposes
    h) Full mouth series and panoramic x-rays.
5. One (1) in a five (5) year period:
    a) Single crowns and onlays;
    b) Single post and core buildups;
    c) Crown buildup including pins;
    d) Prefabricated post and core;
    e) Cast post and core in addition to crown;
    f) Complete dentures;
    g) Partial dentures;
    h) Fixed partial denture (bridge) pontics;
    i) Fixed partial denture (bridge) abutments;
    j) Abutment post and core buildups;
    k) Diagnostic casts;

6. Space maintainers – only eligible for Members through age fifteen 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;
7. Sealants – one per tooth per two-year period through age eleven on permanent first and second molars;
8. Oral surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy and crown lengthening;
9. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than 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;
10. General, IV or Inhalation Sedation is covered for:
    a) 3 or more surgical extractions;
    b) Any number of dentally necessary impactions;
    c) Full mouth or arch alveoloplasty;
    d) Surgical root recovery from sinus;
    e) Medical problem contraindicates local anesthesia;
    f) Children under the age of seven (7) years old.

    General or IV Sedation is not a covered benefit for dental phobic reasons;
11. Restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth;
12. Root canal treatment – one per tooth per lifetime;
13. Root canal retreatment – one per tooth per lifetime;
14. Pupal therapy – through age five on primary anterior teeth and through age eleven on primary posterior teeth;
15. For mucongingingival surgeries, one (1) site is equal to two (2) consecutive teeth or bonded spaces.
16. Scaling and root planing – covered once for each of the four quadrants of the mouth in a 24 month period. Scaling and root planing is limited to two quadrants of the mouth per visit.

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 covered Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield of California or a contracted 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 of California or a contracted 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 contracted 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 thirty 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide a lien calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield and a contracted Dental Plan Administrator, in writing, within ten (10) days after any Recovery has been obtained.

A covered 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 contracted Dental Plan Administrator.

Limitations for Duplicate Coverage

When you are eligible for Medi-Cal

Your Blue Shield of California plan always provides benefits first.

When you are a qualified veteran

If you are a qualified veteran your Blue Shield of California plan will pay the reasonable value or Blue Shield of California's or a contracted Dental Plan Administrator's Allowable Amount for covered services provided to you at a Veteran's Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield of California plan will pay the reasonable value or Blue Shield of California's, or a contracted 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 governmental 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 of California contracted Dental Plan will equal, but not exceed, what Blue Shield of California or a contracted Dental Plan Administrator would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield of California or a contracted 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 of California coordinates your plan benefits in the above situations.

Emergency Services

Emergency Services include covered Services to alleviate severe pain or other symptoms or for the diagnosis and treatment of an unforeseen illness or injury that a reasonable person under the circumstances would believe if not treated immediately could lead to serious jeopardy of health or impairment. The determination of whether the situation required Emergency Services will be made retrospectively by a contracted Dental Plan Administrator based upon an objective review that is consistent with professionally recognized standards of care.

If a Member receives Emergency care outside of California, you will be reimbursed up to the maximum amount listed under the Out-of-Network column in section entitled Summary of Benefits and Member Copayments. The Member will be responsible for the remainder of the Dentist's Billed Charges. Whenever possible, the Member should ask the Dentist to bill the Plan directly.

Payment or reimbursement of Emergency care provided to a Member will be made after a contracted Dental Plan Administrator receives documentation of the charges incurred and upon approval by a contracted Dental Plan Administrator of those

charges set forth. Except for Emergency care, as noted above, a Member will be responsible for full payment of dental services rendered outside of California. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

Dues

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

Please call Customer Service at 1-800-431-2809 to discuss these options or visit the Blue Shield of California internet site at http:///www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield of California

P. O. Box 51827

Los Angeles, CA 90051-6127

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

General Provisions

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 of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

Claims and Services Review

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

Liability of Subscribers in the Event of Non-Payment by Blue Shield of California

In accordance with Blue Shield of California's established policies, and by statute as of 1975, every contract between a contracted 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 medical policy. When Services are provided by a Participating Dentist, the Subscriber is responsible for any applicable deductible or Copayment.

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.

Entire Agreement: Changes

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

Benefits, such as covered Services, Calendar Year Benefits, Deductible, Copayment, or Maximum per Member and Family Copayment/Coinsurance Responsibility amounts are subject to change at any time. Blue Shield of California will provide at least 60 days written notice of any such change.

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

Grace Period

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

Time Limit on Certain Defenses

After a Member has been covered under this Agreement for two (2) consecutive years, Blue Shield of California will not use any omission, misrepresentation, or inaccuracy made by the applicant in an individual application to limit, cancel or rescind an Agreement, den a claim, or raise Dues.

Legal Actions

No action at law in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three (3) years after the time written proof of claim is required to be furnished.

Choice of Providers

Under this Plan, you have a free choice of any licensed Dentist including such providers outside of California.

Facilities (Participating Providers)

The names of Participating Dentists in your area may be obtained by contacting a contracted Dental Plan Administrator at 1-888-679-8928.

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

50 Beale Street

San Francisco, CA 94105

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 Member receiving or providing services, including any physician, hospital, or other provider or their employees.

Endorsements and Appendices

Attached to and incorporated in this Agreement by reference are appendices pertaining to Dues. Endorsements may be issued from time to time subject to the notice provisions of the section entitled Duration of the Agreement. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

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.

Statutory Requirements

This Agreement is subject to the Knox-Keene Health Care Services Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and to Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such Codes shall be binding upon Blue Shield of California whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations, which may include the Health Insurance Portability and Accountability Act. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield of California whether or not such provision is actually included in this Agreement.

Legal Process

Legal process or service upon Blue Shield of California must be served upon a corporate officer of Blue Shield of California.

Non-Assignability

Coverage or any benefits of this Agreement may not be assigned without the written consent of Blue Shield of California.

The coverage and Benefits of this Plan are assignable to Participating and Non-Participating Dentists.

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 1-888-679-8928.

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.

Dental Customer Services

Questions about Services, providers, Benefits, how to use this 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:

1-888-679-8928
Blue Shield of California
Dental Plan Administrator
425 Market Street, 12th Floor
San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

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

Note: Dental Benefit Providers 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. Dental Benefit Providers shall make a decision and notify the Subscriber and Physician within 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

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

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

1-888-679-8928

Blue Shield of California

Dental Plan Administrator

425 Market Street, 12th Floor

San Francisco, CA 94105

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

The grievance system allows Members to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Member 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 the number listed on the last pages of this booklet and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-HMO-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms, and instructions online.

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

Confidentiality of Personal and Health Information

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

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

Blue Shield of California'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 back of this booklet or 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 of California 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 Number:

1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@BlueShieldca.com

Access to Information

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

Public 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 (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
50 Beale Street
San Francisco, CA 94105
Phone: 1-415 229-5065

Procedure

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.

Your name, address, phone number, Subscriber number, and group number should be included with each communication.

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.

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.

Definitions

Whenever the following definitions are capitalized in this booklet, they will have the meaning stated below.

Allowable Amount — the Allowance is:

1. The amount a contracted 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 contracted 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 contracted Dental Plan Administrator determines is appropriate considering the particular circumstances and the Services rendered.

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

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

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.

Copayment — the amount that a Member is required to pay for certain Services after meeting any applicable deductible.

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

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

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

Dental Necessity — Benefits are provided only for Services that are Dentally Necessary as defined in this Section.

1. Services which are Dentally Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards which, as determined by a contracted Dental Plan Administrator, are:

a. Consistent with the symptoms or diagnosis of the condition; and

b. Not furnished primarily for the convenience of the Member, the attending Dentist or other provider; and

c. Furnished in a setting appropriate for delivery of the Service (e.g., a dentist's office).

2. If there are two (2) or more Dentally Necessary Services that can be provided for the condition, Blue Shield will provide benefits based on the most cost-effective Service.

Dental Plan Administrator (DPA) — Blue Shield has contracted with a Dental Plan Administrator (DPA). A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims received from Non-Participating Dentists.

Dentist — a duly licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

Dependent —

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

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

   b. Not covered for Benefits as a Subscriber; and

   c. Not legally separated from the Subscriber; or

2. A Subscriber's Domestic Partner who is:

   a. Not covered for Benefits as a Subscriber; and

   b. A Resident of California.

3. A Subscriber's, spouse's, or Domestic Partner's child (including 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:

   a. A Resident of California; and

   b. 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 guardian); and who has been enrolled and accepted by Blue Shield of California as a Dependent and has maintained membership in accordance with this Agreement.

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

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

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

   c. Thereafter, Certification from a Physician is submitted to Blue Shield of California on the following schedule:

      i. Within 24 months after the month when the Dependent would otherwise have been terminated; and

      ii. 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:

   a. 18 years of age or older; and

   b. Of the same or different sex; and

   c. Residents of California.

2. The partners share:

   a. An intimate and committed relationship of mutual caring; and

   b. The same principal residence.

3. The partners are:

   a. Not currently married; and

   b. Not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited.

4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

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

Elective Dental Procedure — any dental procedures which are unnecessary to the dental health of the patient, as determined by a contracted Dental Plan Administrator.

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.

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.

Maximum Plan Payment — the maximum amount that the Member will be reimbursed for services obtained from a Non-Participating Dentist.

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

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

Person / Member — either a Subscriber or Dependent.

Plan — the Blue Shield of California Dental PPO Plan.

Prosthesis — an artificial part, appliance, or device used to replace a missing part of the body.

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

Resident of California - an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

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

Treatment in Progress — Partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken.

Notice of the Availability of Language Assistance Services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-346-7198與我們聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198 번으로 문의해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。Japanese

خدمات لغوية مجانية. يمكنك الحصول على مترجم شفهي وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាជាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Hmong

IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Office, to take effect on the Subscriber's effective date.

Julie Roberts
Vice President, Office of Health Reform and
General Manager, Individual and Family Plans
Blue Shield of California

Dental Customer Service Telephone Numbers:

Blue Shield of California
Dental Plan Administrator
1-888-679-8928

Blue Shield of California
1-800-431-2809

Dental Customer Service Correspondence Address:
Blue Shield of California
Dental Plan Administrator
Dental Customer Service
425 Market Street, 12th Floor
San Francisco, CA 94105

Claims for all Covered Services should be sent to:
Blue Shield of California
P. O. Box 2722590
Chico, CA 5927-2590

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