

APPLICATION IS HEREBY MADE TO
Blue Shield of California
(California Physicians' Service)

FOR A GROUP DENTAL SERVICE CONTRACT

BY: [GROUP NAME]
[GROUP ADDRESS]
[SAN FRANCISCO] [CA] [99999]

This Contract, number [XYZ999], shall be effective [January1, 2015]. It has been read and approved, and the terms and conditions are accepted by the Contractholder.

The Contractholder, on behalf of itself and its Subscribers, hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between the Contractholder and Blue Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and 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 Contractholder 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 Contractholder or its Subscribers for any of the Plan's obligations to the Contractholder 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.

This application is executed in duplicate. **The Contractholder shall sign, date, and return this original application page to Blue Shield of California by fax to (209) 367-6433.** The Contract shall be retained by the Contractholder. Payment of Dues (Premiums) and acceptance of Blue Shield's performance hereunder by the Contractholder shall be deemed to constitute the Contractholder's acceptance of the terms hereof, whether or not this agreement is signed by the Contractholder.

It is agreed that this application supersedes any previous application for this Contract.

Dated at _____ (City, State)

this _____ day of _____ 20 _____

(Legal Name of Contractholder)

By _____

Title _____

As Contractholder, you are responsible for communicating to Subscribers as soon as possible (and in any case, no later than 30 days after receipt) all changes in Benefits and in any provisions affecting Benefits.

PLEASE SIGN, DATE, AND FAX THE ORIGINAL APPLICATION PAGE
TO BLUE SHIELD OF CALIFORNIA AT (209) 367-6433
or, mail to Blue Shield of California, P.O. Box 629014, El Dorado Hills, CA 95762.

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield of California at the address provided on page GC-1.



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50 Beale Street
San Francisco, California 94105
(415) 229-5000

CHILDREN'S DENTAL HMO SERVICE CONTRACT FOR SHOP*

between

[GROUP NAME]
("Contractholder")

and

California Physicians' Service
dba Blue Shield of California
a not-for-profit corporation

In consideration of the applications and the timely payment of Dues (Premiums), Blue Shield agrees to provide Benefits of this Contract to covered Employees and their covered Dependents.

This Contract shall be effective as of **[January 1, 2015]**, for a term of nine (9) months twelve (12) months, subject to the provisions entitled, "Changes: Entire Contract".

A handwritten signature in black ink, appearing to read "Lou M. Lombardo".

Lou Lombardo, Vice President
Markets Performance and Specialty Benefits
Blue Shield of California

Group Number: **[XYZ999]**

Original Effective Date: **[January1, 2015]**

GC-1

MONTHLY DUES SCHEDULE

Refer to Part V. of this Contract for additional information pertaining to the payment of Dues:

The Contractholder will pay to Blue Shield the following monthly Dues:

| | |
|---|--------|
| Employee (0-18 years old)* | \$0.00 |
| Dependent Spouse/Domestic Partner (0-18 years old)* | \$0.00 |
| Employee (19 years and older)..... | \$0.00 |
| Dependent Spouse/Domestic Partner (19 years and older)..... | \$0.00 |
| Dependent child (0-18 years old)* | \$0.00 |
| Dependent child (0-18 years old)* | \$0.00 |
| Dependent child (0-18 years old)* | \$0.00 |

*The primary Subscriber and Spouse/Domestic Partner age 0-18 do not count towards the three-dependent children maximum rate cap.

IMPORTANT

No Member has the right to receive the Benefits of this Contract for services or supplies furnished following termination of coverage, except as specifically provided in the Group Continuation of Coverage section of the Evidence of Coverage. Benefits of this Contract are available only for services and supplies as included in the applicable sections of the Evidence of Coverage, furnished during the term the Contract is in effect and while the individual claiming Benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in Part VII. General Provisions, D. Changes: Entire Contract, or upon the issuance of a new Contract. 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 Contract.

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PART I. INTRODUCTION

Under the Blue Shield Dental Plan, (Plan), the Plan will provide or arrange for the provision of Benefits to Group employees and their Dependents as Plan Members in accordance with the terms, conditions, Limitations, and Exclusions of this Group Dental Services Contract (“Contract”).

Blue Shield of California’s dental plans are administered by a contracted Dental Plan Administrator (DPA) which is a dental care service plan licensed by the California Department of Managed Health Care, and which contracts with Blue Shield to underwrite and administer the delivery of dental services through a network of Participating Dentists and Dental Centers.

The Evidence of Coverage is included and made part of this Contract.

Contractholder is obtaining the benefits of this Contract through the Small Business Health Options Program (“SHOP”), operated by the California Health Benefit Exchange, dba Covered California (“Covered California”). Blue Shield and Contractholder agree to abide by the rules and requirements established for the purpose of purchasing coverage through the SHOP, and that the obligations under this Contract are to be performed in a manner consistent with such rules and requirements.

Employer’s application for coverage with Blue Shield for one or more of its Employees pursuant to the SHOP will be reviewed by the SHOP for completion and eligibility determination. Blue Shield’s receipt of complete, transmitted application data of Employer from the SHOP will constitute the receipt of that application with Blue Shield. The SHOP will notify Employer of its acceptance and the effective date of coverage for its covered Employees and any Dependents.

PART II. DEFINITIONS

In addition to the provisions contained in the “Definitions” section for the Evidence of Coverage, the following provisions apply to this Contract:

Employee - (1) an individual engaged in the conduct of the business of the Employer and whose duties in such employment are performed at the Employer’s regular places of business. This individual is a permanent employee and works a normal workweek of an average of 30 hours per week over the course of a month. At the option of the Employer and elected prior to issuance of the Contract, an Employee may also include a permanent employee who works at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. An individual who works on a part-time, temporary, or substitute basis is not included in this definition (e.g., short-term employment).

Or (2), a sole proprietor or partner of a partnership engaged on a full-time basis, and who is included as an employee under a health benefit plan of the Employer. A sole proprietor or partner works an average of at least 30 hours per week over the course of a month in the Employer’s business; however, if elected by the Employer prior to issuance of the Contract, the definition will also include a sole proprietor or partner who works at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter.

Qualified Health Plan (QHP) has the same meaning as that term is defined in the Patient Protection and Affordable Care Act Section 1301 (42 USC §18021). If a standalone dental plan is offered through the SHOP, another health plan offered through the SHOP shall not fail to be treated as a QHP solely because the health plan does not offer coverage of benefits offered through the standalone dental plan under 42 USC §18022(b)(1)(J).

PART III. ELIGIBILITY

In addition to the provisions contained in the "Eligibility" section of the Evidence of Coverage, the following provisions apply to this Contract:

A. Employee Eligibility, Waiting Periods and Open Enrollment

The SHOP shall be solely responsible for enrollment and eligibility determinations for eligible Employees and their Dependents, and Blue Shield shall rely upon the accuracy of current eligibility and enrollment information furnished by the SHOP.

B. Associated Employers

Employees of the following listed Employers associated with the Employer as subsidiaries or affiliates are eligible for Benefits in accord with this Contract. For the purposes of this Contract only, service with any associated Employers shall be considered service with the Employer. The Employer may act for and on behalf of any associated Employers in all matters pertaining to this Contract, and every act done by, agreement made with, or notice given to the Employer shall bind all associated Employers.

(list of associated Employers)

None

C. Termination of Benefits

Blue Shield's right to terminate or cancel Benefits under this Contract, including for nonpayment of Premiums by Employers, shall be in accordance with termination rules established by the SHOP per applicable laws, rules and regulations.

In addition to the provisions contained in the "Termination of Benefits" section of the Evidence of Coverage, the following provisions apply to this Contract:

1. The Benefits of a Subscriber shall cease on the first day of the month following the month in which the Subscriber retires, is pensioned, leaves voluntarily, or is dismissed from the employ of the Contractholder or otherwise ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder or is established by the SHOP, except that:
 - a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of Premiums for that Subscriber shall continue coverage in force in accordance with the Employer's policy regarding such coverage; or,
 - b. if the Employer is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of Premiums for that Subscriber shall keep coverage in force for the duration(s) prescribed by the Acts. The Employer is solely responsible for notifying Employees of the availability and duration of family leaves.
2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 31st day at 11:59 p.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written or electronic application for the addition of the Dependent is submitted to and received by Blue Shield within 60 days following the date of birth or placement for adoption.

PART IV. GROUP RENEWAL PROVISIONS

A. Advance Notification of Blue Shield's Intent to Issue a New Group Dental Service Contract

Blue Shield shall effectuate renewals as required by the SHOP.

The Employer shall be notified by Blue Shield or the SHOP of its intent to issue a new Group Dental Service Contract at least [30] days prior to the end of the term of this Contract. However, this advance notification is distinct from, and does not alter the notification periods specified in Part VII. General Provisions, Paragraph D. Changes: Entire Contract.

PART V. DUES (PREMIUMS)

A. Premiums

The monthly Premiums for the Subscriber and any Dependents are shown on the Monthly Dues Schedule Page.

B. When And Where Payable

The SHOP shall be responsible for the collection, aggregation and administration of Premiums. The SHOP will bill the Employer for its enrolled Employees and Dependents itemizing Premiums due to Blue Shield and other SHOP participating carriers selected by Employer's Employees. Premiums are payable by the Employer to the SHOP and the SHOP will forward to Blue Shield those Premiums owed to Blue Shield.

First month's Premium must be paid by the effective date of this Contract. No Member will be covered under this Contract until the first month's Premiums have been received by the SHOP. Subsequent Premiums shall be prepaid in full by the last day of the invoicing month.

A grace period of 30 days to pay all delinquent Premiums and avoid cancellation will be granted for the payment of Premiums accruing, other than those due on the effective date of this Contract. Coverage will continue in force during the grace period, but the Employer shall be liable for the payment of Premiums accruing during the period the Contract continues in force including the grace period. Cancellation for nonpayment of Premiums shall be in accordance with Part VII.B.

- C.** The terms of this Contract or the Premiums payable therefore may be changed from time to time as set forth in Part VII., D. Changes Entire Contract.
- D.** The Employer shall remit to the SHOP the amount specified in Part V. A. ("the base Dues"). If a State or any other taxing authority imposes upon Blue Shield a tax or license fee which is levied upon or measured by the base Premiums or by the gross receipts of Blue Shield or any portion of either, then Blue Shield may amend the Contract to increase the base Premiums by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice which shall not be earlier than the date of the imposition of such tax or license fee, by mailing a postage prepaid notice of the amendment to the Employer at its address of record with Blue Shield at least 30 days before the effective date of the amendment.
- E.** If Benefit amounts are changed due to a change in the terms of this Contract or if a tax is levied under Part V. D., the Premiums charge therefore may be made, or the Premiums credit therefore may be given, as of the effective date of such change.
- F.** A grace period of 30 days to pay all delinquent Premiums and avoid cancellation will be granted for the payment of Premiums accruing, other than those due on the effective date of this Contract, during which period this Contract shall continue in force, but the Employer shall be liable to Blue Shield for the payment of all Premiums accruing during the period the Contract continues in force during the grace period. Cancellation for non-payment of Premiums shall be in accordance with PART VI. B.

PART VI. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. Cancellation Without Cause

The Employer may cancel this Contract at any time by written notice delivered or mailed to Blue Shield and the SHOP, effective on receipt or on such later date as specified in the notice.

B. Cancellation for Non-Payment of Premiums

Blue Shield or the SHOP may cancel this Contract for non-payment of Premiums. If Premiums are not received within fifteen (15) days after the due date as described in PART V. hereof, Blue Shield shall provide written Prospective Notice of Cancellation delivered or sent by e-mail or fax to the Employer, or mailed to the Employer's last address as shown on the records of Blue Shield, stating when, not less than 15 days thereafter, such cancellation shall be effective. If Premiums are not received within the ensuing 15 days, the Contract will be terminated for non-payment on the 15th day following the date of mailing of the Prospective Notice of Cancellation by Blue Shield. In such case, a Notice Confirming Termination of Coverage will be mailed to the Contractholder. A new application for coverage will be required by the Employer and a new contract will be issued only upon demonstration that the Employer meets all underwriting requirements.

C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact or Failure to Provide Records

Blue Shield may cancel or rescind this Contract for fraud or intentional misrepresentation of material fact by the Employer; or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. Fraud or intentional misrepresentations of material fact on an application may, at the discretion of Blue Shield, result in the cancellation or rescission of this Contract. This Contract may also be cancelled for failure to provide Blue Shield with records and information in accordance with state and federal law. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice prior to any rescission.

D. Reinstatement of Contract

If payment for all delinquent Premiums is received by Blue Shield more than 15 days after the date of mailing of the Prospective Notice of Cancellation, pursuant to PART VI. B., the Contract will not be reinstated and Blue Shield will refund such payment to the Employer within 20 business days of receipt; however, Blue Shield shall be entitled to withhold and shall not be required to refund any amount up to the Premiums accruing during the grace period described in Paragraph E., below and in PART V. F. hereof.

E. Grace Period

The Employer shall be entitled to a grace period of 30 days for payment of Premiums, hereof. If during a grace period written notice is given by the Employer to Blue Shield and the SHOP that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Employer or the date of receipt of such written notice, whichever is the later date. The Employer shall be liable to Blue Shield for the payment of pro rata Premiums for the period commencing with the last transmittal date and ending with the date of such discontinuance.

PART VI. CANCELLATION/REINSTATEMENT/GRACE PERIOD

F. Payment or Refund of Dues/Premiums Upon Cancellation

In the event of cancellation, the Employer shall promptly pay any earned Premiums which have not previously been paid. The SHOP shall within 30 days of cancellation (1) return to the Employer the amount of prepaid Premiums, if any, that Blue Shield determines have not been earned as of the effective date of cancellation, and (2) provide Benefits of the Plan for services incurred during the time coverage was in effect up to and including the effective date of cancellation.

G. Termination of Benefits

No Benefits shall be provided for services rendered after the effective date of cancellation, except as specifically provided in the Group Continuation of Coverage section of the Evidence of Coverage.

In the event this Contract is cancelled for any reason, including but not limited to for non-payment of Premiums, no further Benefits will be provided after cancellation.

H. Employer to Provide Subscribers with Notice Confirming Termination of Coverage

If this Contract is rescinded, or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's Notice Confirming Termination of Coverage to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

PART VII. GENERAL PROVISIONS

In addition to the provisions contained in the Evidence of Coverage, the following provisions apply to this Group Dental Service Contract:

A. Choice of Providers

A contracted Dental Plan Administrator has established a network of Dental Centers and Plan Specialists to provide Covered Services to Members. A Member must obtain or receive approval for all Covered Services from his Dental Center. Each Subscriber must select a Dental Center for himself and each of his Dependents from the list of Dental Centers in the Dental HMO Dental Center Directory. The Dental HMO Dental Center Directory will be given to Members at the time of enrollment. A Member's Dental Center will be accessible to the Member on a 24 hour, 7 days a week basis, or will make appropriate arrangements to assure coverage. The Dental HMO Dental Center Directory includes the location and phone numbers of all Dental Centers in the Service Area.

Blue Shield shall provide written notice to the Employer within a reasonable period of time of any termination or breach of Contract of a Plan Provider if such termination or breach may materially affect the Employer or its Subscribers.

Upon termination of a Plan Provider Contract, Blue Shield shall be liable for Benefits rendered by such provider to an eligible Member (other than for Copayments) until the authorized Services being rendered to the Member by the former Plan Provider are completed, unless Blue Shield makes reasonable and medically appropriate provision for the assumption of such Benefits by another Plan Provider.

The Provider Directory is also available electronically on the Covered California website.

B. Use of Masculine Pronoun

Whenever a masculine pronoun is used in this Contract, it shall include the feminine gender unless the context clearly indicates otherwise.

C. Workers' Compensation

This Contract is not in lieu of, and shall not affect, any requirements for coverage by workers' compensation insurance.

D. Changes: Entire Contract

The terms of this Contract, the Dues payable therefor, and the benefits of this Plan, including but not limited to Covered Services and Copayments, may be changed from time to time. Blue Shield will provide at least 30 days' written notice of any such change, and these changes shall not become effective until at least 30 days after written notice of such change is delivered or mailed to the Employer's last address as shown on the records of Blue Shield or the SHOP. Benefits for Services furnished on or after the effective date of any Benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless approved by an executive officer of Blue Shield and a written endorsement is issued. No other representative has authority to change this Contract or to waive any of its provisions.

This Contract, including the appendices, attachments, or other documents incorporated by reference, constitutes the entire agreement between the parties, and any statement made by the Employer or by any Member shall, in the absence of fraud, be deemed a representation and not a warranty.

Notice of changes in Benefits, and any documents that may be delivered to the Employer or the Employer's representative for the purpose of informing members of the details of their coverage under this Contract, will be distributed by the Employer or his representative immediately upon receipt but in no event later than 30 days after receipt of such material.

PART VII. GENERAL PROVISIONS

E. Statutory Requirements

This Contract is subject to the requirements of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of the Act or Regulations shall bind Blue Shield whether or not such provision is actually included in this Contract. In addition, this Contract is subject to applicable state and federal statutes and regulations, which may include the Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act (“HIPAA”), the Patient Protection and Affordable Care Act (“PPACA”), and applicable Centers for Medicare and Medicaid Services (“CMS”) requirements. Any provision required to be in this Contract by reason of such state and federal statutes shall bind the Group and Blue Shield whether or not such provision is actually included in this Contract.

F. Legal Process

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

G. Time of Commencement or Termination

Wherever this Contract provides for a date of commencement or termination of any part or all of this Contract, commencement or termination shall be effective as of 12:01 a.m. Pacific Standard Time of that date.

H. Records and Information to be Furnished

The Employer shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this Plan, to determine the Premiums and to enable it to perform this Contract. CMS specifically requires Blue Shield to obtain the following information: Social Security numbers for Subscribers and dependents over forty-five (45) years of age, Subscriber employment status, Employer identification number and Employer size. Failure to provide any such information required by this Section may result in immediate Cancellation of this Contract.

I. Membership Cards and Evidence of Coverage Booklets

Membership cards will be issued by the Plan for all Subscribers, in addition to an Evidence of Coverage which summarizes the Benefits of this Contract and how to obtain covered Services. The Membership cards will either be sent to the Contractholder for distribution to the Subscribers, or sent directly to the Subscribers, depending on the Contractholder's instructions. The Evidences of Coverage will be sent to the Contractholder for distribution to the Subscribers.

J. Inquiries and Complaints

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to the Plan at the address or telephone number indicated on page CG-1 of this Contract. (See also the Member Services section of the Evidence of Coverage.)

PART VII. GENERAL PROVISIONS

K. Confidentiality

The Contractholder shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health information of Subscribers and Dependents. The Contractholder shall not require Blue Shield to release the personal and health information of individual Subscribers or Dependents without written authorization from the Subscriber, unless permitted by law. No information may be disclosed by either party in violation of Cal. Civ. Code §§ 56, et seq. At the request of the Contractholder, Blue Shield may provide aggregate, encrypted, or encoded data regarding Subscribers and Dependents to the Contractholder, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the Contractholder receives, maintains, or transmits personal or health information of Subscribers or Dependents electronically, the Contractholder shall comply with all state and federal laws relating to the protection of such information including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) provisions on security and confidentiality.

L. ERISA Plan Administrator

If the Contractholder's Plan is governed by ERISA (29 USC Sections 1001, et seq.), it is understood that Blue Shield is not the plan administrator for the purposes of ERISA. The plan administrator is the Contractholder.

PART VIII. CONTRACTHOLDER NOTIFICATION REQUIREMENTS

The Contractholder has various notification requirements under this Group Dental Service Contract. Some of the major Contractholder notification requirements are summarized below. **Note: this summary is not to be construed as an all-inclusive list of the notice requirements of the Contractholder under this Group Dental Service Contract nor does it absolve the Contractholder from any obligations specified elsewhere under this Group Dental Service Contract.**

A. Initial Enrollment

The Employer agrees to offer dental benefits coverage to all eligible Employees during the initial enrollment period.

B. Notification of Cancellation to Subscribers

If this Contract is rescinded, or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's notice of the rescission or cancellation to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

C. COBRA and Cal-COBRA

The following provisions are applicable only when the Contractholder is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] as amended or the California Continuation Benefits Replacement Act [Cal-COBRA]. (See the Continuation of Group Coverage section of the Evidence of Coverage.)

1. COBRA

Blue Shield is not the plan administrator or plan sponsor, as those terms are defined by ERISA, for any purpose, including but not limited to COBRA, and has no responsibility for the Contractholder's COBRA administration obligations

To the extent required by COBRA, and upon timely receipt of dues and proper enrollment forms, Blue Shield will continue the group coverage to qualified beneficiaries after the period that their coverage would normally terminate under the Contract.

Blue Shield will not be responsible for determining whether a Subscriber or Dependent is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by the Contractholder or its COBRA administrator.

If the Contractholder or any Subscriber or Dependent fails to meet its obligations under the Contract and COBRA, Blue Shield shall not be liable for any claims of the Subscriber or Dependent after his/her termination of coverage, except as expressly provided in other applicable provisions of the Contract.

The Contractholder is solely responsible for all aspects of the administration of Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] and any amendments with respect to the group health coverage provided by this Contract. The obligations of the Contractholder, in the event that federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 [COBRA], as amended, apply to the Contractholder, are as set forth below:

- a. Contractholder or its COBRA administrator will complete and timely provide all notices and enrollment forms to all eligible Subscribers and Dependents (including the initial notice of COBRA rights) required under COBRA.
- b. Contractholder or its COBRA administrator will establish procedures to verify eligibility for COBRA coverage and receive COBRA election forms from Qualified Beneficiaries.
- c. The Contractholder will notify its COBRA administrator (or the Plan administrator if the Contractholder does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, or of the Subscriber's Medicare entitlement, or the Employer's (Contractholder's) filing for reorganization under Title XI, United States Code.

PART VIII. CONTRACTHOLDER NOTIFICATION REQUIREMENTS

- d. Contractholder or its COBRA administrator will establish a determination date upon which applicable COBRA rates may be annually changed and determine the applicable premium amount for qualified COBRA beneficiaries in accordance with its Contract with Blue Shield, adding the 2% administrative fee permitted by COBRA.
- e. Contractholder or its COBRA administrator will bill and collect premiums from COBRA Qualified Beneficiaries, and provide timely notification of nonpayment of COBRA continuation coverage premiums, per the terms of the Contract and the COBRA law.
- f. Contractholder or its COBRA administrator will remit premiums to Blue Shield on behalf of the COBRA qualified beneficiary until Blue Shield receives notice from the Contractholder that such beneficiary is no longer entitled to COBRA coverage.
- g. Contractholder or its COBRA administrator will provide notification of conversion rights or other continuation of coverage rights to the extent required by COBRA or any other federal or state laws as applicable, on termination of COBRA coverage. The Contractholder or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.
- h. Contractholder or its COBRA administrator will inform eligible Subscribers and Dependents of changes in the COBRA law as they occur, including an explanation of the impact of these changes upon COBRA coverage.
- i. The Contractholder agrees to assume responsibility for any and all COBRA violations resulting from the failure of the Contractholder or its COBRA administrator to perform its COBRA administration responsibilities.

2. Cal-COBRA

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing within 30 days when the Contractholder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction in hours of employment within 30 days of the Qualifying Event.

EVIDENCE OF COVERAGE

An Evidence of Coverage booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Dental Service Contract. The following pages contain the exact provisions of this Evidence of Coverage and any applicable Supplements and are included as part of this Contract.

Blue Shield of California Children's Dental HMO for SHOP

Summary of Benefits

Group



Blue Shield of California Children’s Dental HMO for SHOP*

Summary of Benefits

This Summary of Benefits is provided with, and is incorporated as part of, the Evidence of Coverage (EOC). The Summary of Benefits provides additional detail for the Dental Care Services that are Benefits under this dental plan and provides the Member’s share-of-costs for these services. Please read both documents carefully for a complete description of provisions, benefits, exclusions, and other important information pertaining to this dental plan.

Services are listed with the American Dental Association (ADA) procedure code. Procedures not listed are not covered. For dental Services received from a Participating Dentist, the Member will be responsible for the amount indicated under the Member Pays column. There is no coverage for dental Services received from a Non-Participating Dentist.

| | |
|--|---------------------------------------|
| Calendar year deductible per member | None |
| Calendar year maximum per member | None |
| Calendar Year Out-of-Pocket Maximum ¹ | \$350 per Member/ \$700 per Family |
| Waiting Period | None |

| ADA Code | Nomenclature | Member pays |
|---|--|-------------|
| | OFFICE VISIT | Nothing |
| D0100 – D0999 I. Diagnostic Services | | |
| D0120 | Periodic oral evaluation - established patient | Nothing |
| D0140 | Limited oral evaluation - problem focused | Nothing |
| D0150 | Comprehensive oral evaluation - new or established patient | Nothing |
| D0190 | Screening of a patient | Nothing |
| D0191 | Assessment of a patient | Nothing |
| D0210 | Intraoral - complete series (including bitewings) - <i>limited to 1 series every 24 months</i> | Nothing |
| D0220 | Intraoral - periapical first film | Nothing |
| D0230 | Intraoral - periapical each additional film | Nothing |
| D0240 | Intraoral - occlusal film | Nothing |
| D0270 | Bitewing - single film | Nothing |
| D0272 | Bitewings - two films | Nothing |
| D0274 | Bitewings - four films - <i>limited to 1 series every 6 months</i> | Nothing |
| D0330 | Panoramic film | Nothing |
| D0350 | Photograph 1st | Nothing |
| D0350 | Photograph each additional (up to 7) | Nothing |
| D0460 | Pulp vitality tests | Nothing |
| D0473 | Diagnostic casts | Nothing |
| D0601 | Caries risk assessment and documentation, with a finding of low risk ⁵ | Nothing |

* Underwritten by Blue Shield of California and pending regulatory approval.

Blue Shield of California Children's Dental HMO for SHOP

| ADA Code | Nomenclature | Member pays |
|--|--|-------------|
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk ⁵ | Nothing |
| D0603 | Caries risk assessment and documentation, with a finding of high risk ⁵ | Nothing |
| D1000 – D1999 II. Preventive Services | | |
| Dental Prophylaxis | | |
| D1110 | Prophylaxis - adult | Nothing |
| D1120 | Prophylaxis - child | Nothing |
| D1206 | Topical application of fluoride varnish | Nothing |
| D1208 | Topical application of fluoride | Nothing |
| D1330 | Oral hygiene instructions | Nothing |
| D1351 | Sealant - per tooth | Nothing |
| Space Maintenance (Passive Appliances) | | |
| D1510 | Space maintainer - fixed - unilateral | Nothing |
| D1515 | Space maintainer - fixed - bilateral | Nothing |
| D1525 | Space maintainer - removable - bilateral | Nothing |
| D2000 – D2999 III. Restorative | | |
| Amalgam Restorations | | |
| D2140 | Amalgam - one surface, primary or permanent | \$25 |
| D2150 | Amalgam - two surfaces, primary or permanent | \$30 |
| D2160 | Amalgam - three surfaces, primary or permanent | \$40 |
| D2161 | Amalgam - four or more surfaces, primary or permanent | \$45 |
| D2330 | Resin based composite - one surface, anterior | \$30 |
| D2331 | Resin based composite - two surfaces, anterior | \$45 |
| D2332 | Resin based composite - three surfaces, anterior | \$55 |
| D2335 | Resin based composite - four or more surfaces or involving incisal angle, anterior | \$60 |
| Inlay/Onlay Restorations | | |
| D2510 | Inlay - metallic - two surfaces | \$185 |
| D2520 | Inlay - metallic - three surfaces | \$200 |
| D2530 | Inlay - metallic - four or more surfaces | \$215 |
| D2542 | Onlay - metallic - two surfaces | \$185 |
| D2543 | Onlay - metallic - three surfaces | \$200 |
| D2544 | Onlay - metallic - four or more surfaces | \$215 |
| Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays² | | |
| D2710 | Crown - resin-based composite (indirect) | \$140 |
| D2740 | Crown - porcelain/ceramic substrate | \$300 |
| D2750 | Crown - porcelain fused to high noble metal | \$300 |
| D2751 | Crown - porcelain fused to predominantly base metal | \$300 |
| D2752 | Crown - porcelain fused to noble metal | \$300 |
| D2781 | Crown - 3/4 cast predominantly base metal | \$300 |
| D2790 | Crown - full cast high noble metal | \$300 |
| D2791 | Crown - full cast predominantly base metal | \$300 |

Blue Shield of California Children's Dental HMO for SHOP

| ADA Code | Nomenclature | Member pays |
|---|---|-------------|
| D2792 | Crown - full cast noble metal | \$300 |
| D2920 | Recement crown | \$25 |
| Other Restorative Services | | |
| D2930 | Prefabricated stainless steel crown - primary tooth | \$65 |
| D2931 | Prefabricated stainless steel crown - permanent tooth | \$75 |
| D2940 | Protective restoration | \$25 |
| D2951 | Pin retention - per tooth, in addition to restoration | \$25 |
| D2952 | Post and core in addition to crown, indirectly fabricated | \$100 |
| D2954 | Prefabricated post and core in addition to crown | \$90 |
| D2980 | Crown repair, necessitated by restorative material failure | \$50 |
| D3000 - D3999 IV. Endodontics | | |
| D3110 | Pulp cap (direct) excluding final restoration | \$20 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | \$40 |
| Endodontic Therapy on Primary Teeth | | |
| D3310 | Endodontic therapy - anterior tooth (excluding final restoration) | \$195 |
| D3320 | Endodontic therapy - bicuspid tooth (excluding final restoration) | \$235 |
| D3330 | Endodontic therapy - molar tooth (excluding final restoration) | \$300 |
| Endodontic Treatment | | |
| D3346 | Retreatment of previous root canal - anterior | \$240 |
| D3347 | Retreatment of previous root canal - bicuspid | \$295 |
| D3348 | Retreatment of previous root canal - molar | \$365 |
| Apexification/Recalcification and Pulpal Regeneration Procedures | | |
| D3351 | Apexification/recalcification - initial visit (apical closure/calccific repair of perforations, root resorption, etc.) | \$85 |
| D3352 | Apexification/recalcification - interim medication replacement (apical closure/calccific repair of perforations, root resorption, etc.) | \$45 |
| D3353 | Apexification/recalcification - final visit (apical closure/calccific repair of perforations, root resorption, etc.) | \$110 |
| Apicoectomy/Periradicular Services | | |
| D3410 | Apicoectomy / periradicular surgery - anterior | \$240 |
| D3421 | Apicoectomy / periradicular surgery - bicuspid, first root | \$250 |
| D3425 | Apicoectomy / periradicular surgery - molar, first root | \$275 |
| D3430 | Retrograde filling - per root | \$90 |
| D3450 | Root amputation - per root | \$110 |
| D4000 - D4999 V. Periodontics | | |

Blue Shield of California Children's Dental HMO for SHOP

| ADA Code | Nomenclature | Member pays |
|---|---|-------------|
| Surgical Services (including usual postoperative care) | | |
| D4210 | Gingivectomy/gingivoplasty four or more contiguous teeth or tooth bounded spaces per quadrant | \$150 |
| D4211 | Gingivectomy/gingivoplasty one to three contiguous teeth or tooth bounded spaces per quadrant | \$50 |
| D4260 | Osseous surgery (including flap entry and closures) - four or more contiguous teeth or tooth bounded spaces - per quadrant | \$265 |
| Non-Surgical Periodontal Service | | |
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant | \$55 |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant | \$30 |
| D5000 - D5899 VI. Prosthodontics (removable) | | |
| Complete Dentures (including routine post-delivery care) | | |
| D5110 | Complete denture - maxillary | \$300 |
| D5120 | Complete denture - mandibular | \$300 |
| D5130 | Immediate denture - maxillary | \$300 |
| D5140 | Immediate denture - mandibular | \$300 |
| Partial Dentures (including routine post-delivery care) | | |
| D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | \$300 |
| D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | \$300 |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$335 |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$335 |
| Adjustments To Dentures | | |
| D5410 | Adjust complete denture - maxillary | \$20 |
| D5411 | Adjust complete denture - mandibular | \$20 |
| D5421 | Adjust partial denture - maxillary | \$20 |
| D5422 | Adjust partial denture - mandibular | \$20 |
| Repairs to Complete Dentures | | |
| D5510 | Repair broken complete denture base | \$40 |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | \$40 |
| Repairs to Partial Dentures | | |
| D5610 | Repair resin denture base | \$40 |
| D5620 | Repair cast framework | \$50 |
| D5630 | Repair or replace broken clasp | \$50 |
| D5640 | Replace broken teeth - per tooth | \$35 |
| D5650 | Add tooth to existing partial denture | \$35 |
| D5660 | Add clasp to existing partial denture | \$60 |

Blue Shield of California Children's Dental HMO for SHOP

| ADA Code | Nomenclature | Member pays |
|---|---|-------------|
| Denture Reline Procedures | | |
| D5730 | Reline complete maxillary denture - (chairside) | \$60 |
| D5731 | Reline complete mandibular denture - (chairside) | \$60 |
| D5740 | Reline maxillary partial denture - (chairside) | \$60 |
| D5741 | Reline mandibular partial denture - (chairside) | \$60 |
| D5750 | Reline complete maxillary denture - (laboratory) | \$90 |
| D5751 | Reline complete mandibular denture - (laboratory) | \$90 |
| D5760 | Reline maxillary partial denture - (laboratory) | \$80 |
| D5761 | Reline mandibular partial denture - (laboratory) | \$80 |
| Interim Prosthesis | | |
| D5820 | Interim partial denture (maxillary) | \$85 |
| D5821 | Interim partial denture (mandibular) | \$85 |
| D5850 | Tissue conditioning - maxillary | \$30 |
| D5851 | Tissue conditioning - mandibular | \$30 |
| D6200 - D6999 IX. Prosthodontics, fixed | | |
| Fixed Partial Denture Pontics² | | |
| D6210 | Pontic - cast high noble metal | \$300 |
| D6211 | Pontic - cast predominantly base metal | \$300 |
| D6212 | Pontic - cast noble metal | \$300 |
| D6240 | Pontic - porcelain fused to high noble metal | \$300 |
| D6241 | Pontic - porcelain fused to predominantly base metal | \$300 |
| D6242 | Pontic - porcelain fused to noble metal | \$300 |
| D6251 | Pontic - resin with predominantly base metal | \$300 |
| D6545 | Retainer - cast metal for resin bonded fixed prosthesis | \$130 |
| D6740 | Crown - porcelain/ceramic | \$300 |
| D6750 | Crown - porcelain fused to high noble metal | \$300 |
| D6751 | Crown - porcelain fused to predominantly base metal | \$300 |
| D6752 | Crown - porcelain fused to noble metal | \$300 |
| D6780 | Crown - 3/4 cast high noble metal | \$300 |
| D6790 | Crown - full cast high noble metal | \$300 |
| D6791 | Crown - full cast predominantly base metal | \$300 |
| D6792 | Crown - full cast noble metal | \$300 |
| D6930 | Recement fixed partial denture | \$40 |
| Other Fixed Partial Denture Services | | |
| D6980 | Fixed partial denture repair as necessitated by restorative material failure | \$95 |
| D7000 - D7999 X. Oral and Maxillofacial Surgery | | |
| Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care) | | |
| D7111 | Extraction of coronal remnants - deciduous tooth | \$40 |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | \$65 |
| D7210 | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | \$120 |
| D7220 | Removal of impacted tooth - soft tissue | \$95 |

Blue Shield of California Children's Dental HMO for SHOP

| ADA Code | Nomenclature | Member pays |
|--|--|-------------|
| D7230 | Removal of impacted tooth - partial bony | \$145 |
| D7240 | Removal of impacted tooth - complete bony | \$160 |
| D7250 | Surgical removal of residual tooth roots | \$80 |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | \$185 |
| D7285 | Biopsy of oral tissue - hard (bone, tooth) ³ | \$180 |
| D7286 | Biopsy of oral tissue - soft ³ | \$110 |
| Alveoloplasty - Surgical Preparation of Ridge | | |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$85 |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$50 |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$120 |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$65 |
| D7410 | Excision of benign lesion up to 1.25 cm | \$75 |
| D7411 | Excision of benign lesion greater than 1.25 cm | \$115 |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | \$180 |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm | \$330 |
| D7460 | Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm | \$155 |
| D7461 | Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm | \$250 |
| Vestibuloplasty | | |
| D7472 | Removal of torus palatinus | \$145 |
| D7473 | Removal of torus mandibularis | \$140 |
| Surgical incision | | |
| D7510 | Incision & drainage of abscess - intraoral soft tissue | \$70 |
| D7520 | Incision and drainage of abscess - extraoral soft tissue | \$70 |
| D7960 | Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure | \$120 |
| D8000 - D8999 XI. Orthodontics⁴ | | |
| Medically necessary orthodontia includes at least D0140 and D0470 (see descriptions below) | | |
| D0140 | Initial orthodontic examination called the Limited Oral Evaluation must be conducted. This examination includes completion of the HLD Score sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the patient qualifies for medically necessary orthodontic services. Those qualifying conditions are: <ul style="list-style-type: none"> • Cleft lip and or palate deformities • Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins | \$350 |

Blue Shield of California Children's Dental HMO for SHOP

| ADA Code | Nomenclature | Member pays |
|------------------------------------|---|-------------|
| | <p>syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hemi-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.</p> <ul style="list-style-type: none"> • Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite). • Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program. • Severe traumatic deviation must be justified by attaching a description of the condition. • Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm. The remaining conditions must score 26 or more to qualify (based on the HDL Index). | |
| D0470 | Diagnostic casts may be provided only if one of the above conditions is present | |
| Adjunctive General Services | | |
| Unclassified Treatment | | |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | \$30 |
| Anesthesia | | |
| D9215 | Local anesthesia in conjunction with outpatient surgical procedures | \$15 |
| D9220 | Deep sedation/general anesthesia - first 30 minutes | \$95 |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes | \$40 |
| D9230 | Analgesia nitrous oxide | \$15 |
| D9248 | Non-intravenous conscious sedation | \$65 |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | \$50 |
| Professional Visits | | |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | \$20 |
| D9440 | Office visit - after regularly scheduled hours | \$45 |
| D9630 | Other drugs and/or medications, by report | \$15 |
| D9920 | Behavior management, by report | \$35 |
| D9930 | Treatment of complications (post-surgical) - unusual circumstances, by report | \$35 |
| Other | | |
| D9999 | Unspecified adjunctive procedure, by report - <i>includes failed Appointment (without 24-hour notice)</i> - | Nothing |

Blue Shield of California Children’s Dental HMO for SHOP

| ADA Code | Nomenclature | Member pays |
|----------|---|-------------|
| | <i>per 15 minutes of appointment time – up to an overall maximum of \$40.00</i> | |
| D777 | Broken appointment without 24 hour notification | Nothing |

- 1 For families with two (2) or more children covered under this dental plan, the Out-of-Pocket Maximum is limited to \$700 for all children (\$350 per child, maximum not to exceed \$700). The Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Once the Out-Of-Pocket Maximum has been reached, the plan pays all costs for covered services from participating dentists for that child or children. Costs for non-Covered Services, services from Non-Participating Dentists and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum.
- 2 The cost of precious metals used in any form of dental benefits is the responsibility of the member.
- 3 Member pays lab fees for biopsies and excisions.
- 4 Medically necessary orthodontia services include an oral evaluation and diagnostic casts. An initial orthodontic examination (a Limited Oral Evaluation) must be conducted which includes completion of the Handicapping Labio-Lingual Deviation (HLD) Score sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the Member qualifies for medically necessary orthodontic services. Diagnostic casts may be covered only if qualifying conditions are present. Pre-certification for all orthodontia evaluation and services is required.
- 5 Caries Risk Management - CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child’s risk level for caries (decay). Children assessed as having a “high risk” for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; “medium risk” children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and “low risk” children will be allowed up to two fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

Benefits are subject to modification for subsequently enacted state or federal legislation.

NOTE: To purchase a Family Dental Plan (Adult and Pediatric), only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan, On and Off Exchange, are eligible to purchase the Family Pediatric and Adult dental plans. If a child is enrolled in the Family Pediatric Dental Plan, all children in the family under 19 years of age must be enrolled in the same Family pediatric dental Plan. Adults eligible to purchase a Family Adult Dental Plan must have purchased a Platinum, Gold, Silver or Bronze Qualified Health Plan on or off the Exchange.

Blue Shield of California Children's Dental HMO for SHOP

Covered Services and Supplies

The covered Services and supplies listed below are payable at the applicable Copayment amounts listed in the Summary of Benefits and are subject to all applicable provisions of the EOC.

Diagnostic and Preventive Care Services - covers initial and periodic oral examinations, consultations, including specialist consultations, caries risk management (CAMBRA) procedures, topical fluoride treatment, preventive dental education and oral hygiene instruction, roentgenology (x-rays), prophylaxis services (cleanings), space maintainers and dental sealant treatments.

Restorative Dentistry (Fillings) - covers amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries, micro-filled resin restorations which are non-cosmetic, replacement of a restoration, use of pins and pin build-up in conjunction with a restoration, sedative base and sedative fillings.

Oral Surgery - covers extractions, including surgical extractions, removal of impacted teeth, biopsy of oral tissues, alveolectomies, excision of cysts and neoplasms, treatment of palatal torus, treatment of mandibular torus, frenectomy, incision and drainage of abscesses, post-operative services, including exams, suture removal and treatment of complications and root recovery (separate procedure).

The surgical removal of impacted teeth is a Benefit only when evidence of pathology exists.

Endodontic - covers direct pulp capping, pulpotomy and vital pulpotomy, apexification filling with calcium hydroxide, root amputation, root canal therapy, including culture canal, retreatment of previous root canal therapy, apicoectomy and vitality tests.

Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.

- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontics - covers treatment for Emergency Services, including treatment for periodontal abscess and acute periodontitis, periodontal scaling and root planing, and subgingival curettage, gingivectomy and osseous or mucogingival surgery.

Crown and Fixed Bridges - covers crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold only or three quarter crown, and stainless steel, related dowel pins and pin build-up, fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, recementation of crowns, bridges, inlays and onlays, cast post and core, including cast retention under crowns and repair or replacement of crowns, abutments or pontics.

Removable Prosthetics - covers dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, office or laboratory relines or rebases, denture repair, denture adjustment, tissue conditioning, denture duplication and stayplates.

Other Benefits - covers local anesthetics, oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure, nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of licensure, treatment for Emergency Services, palliative treatment and coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for Dental Care Services.

Orthodontics - non-medically necessary orthodontic treatment is not a benefit of this dental plan. Medically necessary treatment may be provided if the Member meets the eligibility requirements for medically necessary orthodontia coverage under the California Children's Services (CCS) program based on the Handicapping Labio-Lingual Deviation (HLD) Score Sheet.

Blue Shield of California Children's Dental HMO for SHOP

Evidence of Coverage

Group

About this Blue Shield of California Children’s Dental Plan*: This plan provides pediatric oral care coverage to meet the essential health benefits requirements of the Affordable Care Act. This dental plan is part of a package that consists of a health plan and a dental plan which is offered at a package rate. This Evidence of Coverage describes the Benefits of the dental plan as part of the package. Benefits of this pediatric dental plan are provided only to Members under the age of 19.

NOTICE

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

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

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

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Member Services at the address or telephone number listed in the Member Services paragraphs of the Other Provisions section of this booklet.

IMPORTANT

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

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

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

IMPORTANT

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

* Underwritten by Blue Shield of California and pending regulatory approval.

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I. INTRODUCTION TO THE BLUE SHIELD OF CALIFORNIA CHILDREN'S DENTAL HMO PLAN

Your interest in the Blue Shield Children's Dental HMO Plan is truly appreciated. Blue Shield has been serving Californians for over 60 years, and we look forward to serving your dental care needs.

You will have the opportunity to be an active participant in your own dental care. The Blue Shield Children's Dental HMO Plan will help you make a personal commitment to maintaining and, where possible, improving your dental health status. Like you, we believe that maintaining a healthy lifestyle and preventing dental illness are as important as caring for your needs when dental problems arise.

Please review this booklet which summarizes the coverage and general provisions of the Blue Shield Dental Children's HMO Plan.

Blue Shield of California's dental plans are administered by a contracted Dental Plan Administrator (DPA).

If you have any questions regarding the information in this booklet, need assistance, or have any problems, you may contact Blue Shield or your dental Member Services Department:

GENERAL AND ELIGIBILITY INQUIRY:

In California..... 1-800-585-8111

Outside California..... 1-800-323-7201

PROBLEM RESOLUTION AND/OR GRIEVANCES:

In California..... 1-800-585-8111

Outside California..... 1-800-323-7201

Blue Shield of California's dental plans are designed to reduce the cost of dental care to you, the Subscriber. In order to reduce your costs, much greater responsibility is placed on you for managing the Benefits provided under the dental plans. All subscribers, including adults, enrolled in a health plan directly through Blue Shield must be enrolled in a pediatric dental plan. Although subscribers 19 years of age and older must select a pediatric dental plan, they will not be eligible for benefits and the pediatric dental rate will not apply.

This dental plan is offered through Covered California's Small Business Health Options Program (SHOP). For more information about Covered California and the SHOP, please visit www.coveredca.com or call 1-888-975-1142.

II. EVIDENCE OF COVERAGE STATEMENT

This Evidence of Coverage booklet constitutes only a summary of the Plan. The Dental Con-

tract must be consulted to determine the exact terms and conditions of coverage. The Dental Services Contract is available through your employer or a copy can be furnished upon request. Your employer is familiar with this Plan, and you may also direct questions concerning Covered Services or specific Plan provisions to the Blue Shield Plan Member Services Department.

III. CHOICE OF DENTAL PROVIDER

SELECTING A DENTAL PROVIDER

A close Dentist-patient relationship is an important element that helps to ensure the best dental care. Each Member is therefore required to select a Dental Provider at the time of enrollment. This decision is an important one because your Dental Provider will:

1. Help you decide on actions to maintain and improve your dental health.
2. Provide, coordinate and direct all necessary Covered Dental Care Services.
3. Arrange referrals to Plan Specialists when required, including the prior Authorization you will need.
4. Authorize Emergency Services when necessary.

The Dental Provider for each Member must be located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by the Plan.

A Dental Provider must also be selected for a newborn or child placed for adoption.

If you do not select a Dental Provider at the time of enrollment or seek assistance from the Dental Plan Member Services Department within 15 days of the effective date of coverage, the Plan will designate a temporary Dental Provider for you and your Dependents, and notify you of the designated Dental Provider. This designation will remain in effect until you advise the Plan of your selection of a different Dental Provider.

You should contact Dental Plan Member Services if you need assistance locating a Dental Plan Provider in your Service Area. The Plan will review and consider your request for services that cannot be reasonably obtained in network. If your request for services from a Non-Plan Provider is approved, the Plan will pay for Covered Services from the Non-Plan Provider.

CHANGING DENTAL PROVIDERS

You or a Dependent may change Dental Providers without cause at the following times:

1. during open enrollment;
2. when your change in residence makes it inconvenient to continue with the same Dental Provider;

3. one other time during the Calendar Year.

If you want to change Dental Providers at any of the above times, you must contact Dental Member Services. Before changing Dental Providers you must pay any outstanding Copayment balance owed to your existing Dental Provider. The change will be effective the first day of the month following notice of approval by the Plan.

If your Dental Provider ceases to be in the Plan Provider network, the Plan will notify you in writing. To ensure continuity of care you will temporarily be assigned to an alternate Dental Provider and asked to select a new Dental Provider. If you do not select a new Dental Provider within the specified time, your alternate Dental Provider assignment will remain in effect until you notify the Plan of your desire to select a new Dental Provider.

CONTINUITY OF CARE BY A TERMINATED PROVIDER

Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving a contracted Dental Plan Administrator's Plan Provider Network. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

CONTINUITY OF CARE FOR NEW MEMBERS BY NON-CONTRACTING PROVIDERS

Newly covered Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age; or who have received authorization from a provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracting provider who was providing services to the Member at the time the Member's coverage became effective under this Plan. Contact Member Services to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

PAYMENT OF PROVIDERS

Blue Shield contracts with a contracted Dental Plan Administrator to provide Services to our Members. A monthly fee is paid to a contracted Dental Plan Administrator for each Member. This payment system includes incentives to a contracted Dental Plan Administrator to manage all Covered Services provided to Members in an appropriate manner consistent with the Contract.

Your Dental Provider must obtain authorization from a contracted Dental Plan Administrator before referring you to providers outside of the Dental Center.

If you want to know more about this payment system, contact a contracted Dental Plan Administrator at the number shown in the Member Services section of this booklet or talk to your Plan Provider.

RELATIONSHIP WITH YOUR DENTAL PROVIDER

The Dentist-patient relationship you establish with your Dental Provider is very important. The best effort of your Dental Provider will be used to ensure that all Medically Necessary and appropriate professional Services are provided to you in a manner compatible with your wishes.

If your Dentist recommends procedures or treatment which you refuse, or you and the Dental Provider fail to establish a satisfactory relationship, you may select a different Dental Provider. The Plan Member Services can assist you with this selection.

Your Dental Provider will advise you if they believe there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the recommended treatment or procedure, the Plan Member Services can assist you in the selection of another Dental Provider.

IV. HOW TO USE YOUR DENTAL PLAN

USE OF DENTAL PROVIDER

At the time of enrollment, you will choose a Dental Provider that will provide and coordinate all covered dental Services. You must contact your Dental Provider for all dental care needs including preventive Services, routine dental problems, consultation with Plan Specialists and Emergency Services. The Dental Provider is responsible for providing general Dental Care Services and coordinating or arranging for referral to other necessary Plan Specialists. The Plan must authorize such referrals.

To avoid a failed/broken appointment charge, you must always cancel any scheduled appointments at least 24 hours in advance.

To obtain Benefits under your Plan, you must attend the Dental Provider you selected. If for any reason you did not select a Dental Provider, contact Member Services at:

In California.....1-800-585-8111

Outside California.....1-800-323-7201

REFERRAL TO PLAN SPECIALISTS

All specialty Dental Care Services must be provided by or arranged for by the Dental Provider. Referral by a Dental Provider does not guarantee coverage for the services for which the Member is being referred. The Benefit and eli-

gibility provisions, exclusions, and limitations will apply. Members may be referred to a Plan Specialist within the Dental Center. However, you may also be referred to a Plan Specialist outside of the Dental Center if the type of Specialty Service needed is not available within your Dental Center.

If the Dental Provider determines specialty Dental Care Services are necessary, they will complete a referral form and notify a contracted Dental Plan Administrator. A contracted Dental Plan Administrator then must authorize such referrals. When no Plan Dentist is available to perform the needed Service, the Dental Provider will refer you to a non-Plan dentist after obtaining Authorization from a contracted Dental Plan Administrator. This Authorization procedure is handled for you by your Dental Provider.

Generally, your Dental Provider will refer you within the network of Blue Shield Plan Specialists in your area. After the Specialty Services have been rendered, the Plan Specialist will provide a complete report to your Dental Provider to ensure your dental record is complete.

EMERGENCY SERVICES

An emergency means, “an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in any of the following: (1) placing the member’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) subjecting the member to undue suffering.”

For Emergency Services within your Service Area you should first notify your Dental Provider to obtain care, authorization, or instructions for care prior to actual Emergency treatment. If it is not possible to notify your Dental Provider prior to receiving Emergency Services, you must notify your Dental Provider within 24 hours after care is received unless it was not reasonably possible to communicate within this time limit. In such case, notice must be given as soon as possible. Failure to provide notice as stated may result in the services not being covered.

If you are in need of emergency treatment and are outside the geographic area of your designated Dental Provider, you should first contact a contracted Dental Plan Administrator to describe the emergency and receive referral instructions. If a contracted Dental Plan Administrator does not have a contracted dentist in the area, or if you are unable to contact a contracted Dental Plan Administrator, you should contact a dentist of your choice. Emergency treatment refers only to those dental services required to alleviate pain and suffering. You will be directly reimbursed for this treatment up to the maximum allowed under your Plan Benefits. Refer to the section titled “Responsibility for Copayments, Charges for non-Covered Services and Emergency Claims” within the insert.

NOTE: A contracted Dental Plan Administrator will respond to all requests for prior authorization of services as follows:

for emergency services, as soon as possible to accommodate the Member’s condition not to exceed 72 hours from receipt of the request;

for other services, within 5 business days from receipt of the request.

If you obtain services without prior Authorization from a contracted Dental Plan Administrator, a contracted Dental Plan Administrator will retrospectively review the services for coverage as Emergency Services. If a contracted Dental Plan Administrator determines that the situation did not require Emergency Services, you will be responsible for the entire cost of the services. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

LIMITATION OF MEMBER LIABILITY

Members shall not be responsible to Plan Providers for payment of a Service if the Service is a Benefit of the Plan. When Covered Services are rendered by a Plan Dentist, the Member is responsible only for the applicable Copayments and charges in excess of Benefit maximums. Members are responsible for the full charges for any non-covered services they obtain.

If a Dental Provider ceases to be in the Plan Provider network, you will be notified if you are affected. The Plan will make every reasonable and appropriate provision to have another Dental Provider assume responsibility for your dental care. Once provisions have been made for the transfer of your care, services of a former Plan Dentist are no longer covered, except as provided under Section III., Choice of Dental Provider, Continuity of Care by a Terminated Provider.

You will not be responsible for payment (other than Copayments) to a former Plan Dentist for any Covered Services you receive prior to the effective date of the transfer to a new Dental Provider.

RESPONSIBILITY FOR COPAYMENTS AND EMERGENCY CLAIMS

Member Responsibility

The Member shall be responsible to the Dental Provider and other Plan Providers for payment of the following charges:

1. Any amounts listed under Copayments in the Dental HMO Summary of Benefits.
2. Any charges for non-covered services.

All such Copayments and charges for non-covered services are due and payable to the Dental Provider or Plan Providers immediately upon commencement of extended treatments or upon the provision of services. Termination of the Plan shall in no way affect or limit any liability or obligation of the Member to the Dental Provider or other Plan Provider for any such Copayments or charges owing.

Emergency Claims

If Emergency Services outside of the Service Area were received and expenses were incurred by the Member, the Member must submit a complete claim with the Emergency Service record (a copy of the Dentist's bill) for payment to a contracted Dental Plan Administrator, within 1 year after the treatment date.

Please send this information to:

Blue Shield of California
P.O. Box 272590
Chico, CA 95927-2590

If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not pre-authorized, a contracted Dental Plan Administrator will review the claim retrospectively. If a contracted Dental Plan Administrator determines that the services were not Emergency Services and would not otherwise have been authorized by a contracted Dental Plan Administrator, and, therefore, are not Covered Services under the dental Plan Contract, it will notify the Member of that determination. The Member is responsible for the payment of such Dental Care Services received. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim. If the Member disagrees with a contracted Dental Plan Administrator's decision, he may appeal using the procedures outlined in the section entitled "Member Services and Grievance Process".

Out-of-Pocket Maximum

The out-of-pocket maximum per Member for all Covered Services and supplies is specified on the Summary of Benefits. This amount is the most the Member pays during the coverage period (usually one year) for the Member's share of the cost of covered services. This limit helps the Member plan for dental care expenses.

Member Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments by the Plan for covered Services provided under the Plan.

BLUE SHIELD ONLINE

Blue Shield's internet site is located at <http://www.blueshieldca.com>. Members using a personal computer and modem with World Wide Web access may view and download healthcare information and software.

V. PLAN BENEFITS

The Benefits available to you under the Plan are listed in the Summary of Benefits which is incorporated as part of this Evidence of Coverage. Benefits are provided only to Members under the age of 19. The Copayments for these Services, if applicable, are also listed in the Summary of Benefits.

IMPORTANT INFORMATION

The Dental Care Services (Benefits) described in this booklet and its accompanying insert are covered only if they are of Dental Necessity and are provided, prescribed, or referred by your Dental Provider and are approved by a contracted Dental Plan Administrator. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, and to the General Exclusions and Limitations set forth in the General Exclusions and Limitations section of this booklet. A contracted Dental Plan Administrator will not pay charges incurred for services without your Dental Provider's and/or a contracted Dental Plan Administrator's prior Authorization except for Emergency Services obtained in accordance with Section IV, How To Use Your Dental Plan.

The determination of whether services are of Dental Necessity or are an emergency will be made by a contracted Dental Plan Administrator. This determination will be based upon the Plan's review consistent with generally accepted dental standards, and will be subject to grievance in accordance with the procedures outlined in Section XI, Member Services and Grievance Process.

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.

VI. 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 for:

1. dental services not appearing on the Summary of Benefits.

2. dental services in excess of the limits specified in the Limitations section of this Evidence of Coverage;
3. services of dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Dental Provider and authorized by the Plan, or when required in a covered emergency;
4. any dental services received or costs that were incurred in connection with any dental procedures started prior to the Member's effective date of coverage. This exclusion does not apply to Covered Services to treat complications arising from services received prior to the Member's effective date of coverage;
5. any dental services received subsequent to the time the Member's coverage ends;
6. experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;
7. dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
8. procedures, appliances, or restorations to correct congenital or developmental malformations unless specifically listed in the Summary of Benefits;
9. cosmetic dental care;
10. general anesthesia or intravenous/conscious sedation unless specifically listed as a benefit under the Summary of Benefits or is given by a Dentist for a covered oral surgery;
11. hospital charges of any kind;
12. major surgery for fractures and dislocations;
13. loss or theft of dentures or bridgework;
14. malignancies;
15. dispensing of drugs not normally supplied in a dental office;
16. additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member;
17. the cost of precious metals used in any form of dental benefits;
18. surgical removal of implants;
19. services of a pedodontist/pediatric Dentist for Member except when a Member child is unable to be treated by his or her Dental Provider or treatment is Dentally Necessary or his or her Dental Provider is a pedodontist/pediatric Dentist.
20. charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;
21. treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;
22. treatment for which payment is made by any governmental agency, including any foreign government;
23. charges for second opinions, unless previously authorized by the contracted Dental Plan Administrator;
24. charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
25. services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;
26. all implant and orthodontic services (medically and non-medically necessary).

Orthodontic Limitations & Exclusions

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

Those immediate qualifying conditions are:

1. Cleft lip and or palate deformities
2. Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
5. Severe traumatic deviation must be justified by attaching a description of the condition.
6. Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.

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

Excluded are the following conditions:

- Crowded dentitions (crooked teeth)
- Excessive spacing between teeth
- Temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies

- Treatment in progress prior to the effective date of this coverage.
- Extractions required for orthodontic purposes
- Surgical orthodontics or jaw repositioning
- Myofunctional therapy
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan or for changes in Orthodontic treatment necessitated by any kind of accident
- Palatal expansion appliances
- Services performed by outside laboratories
- Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

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

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 Summary of Benefits, will be subject to Limitations as set forth below. Services identified as optional are not covered. If a Member chooses to receive an optional service, the Member will be responsible for the difference in cost between the Covered Service and the optional service, unless otherwise specified below:

1. Roentgenology (x-rays) are limited as follows:

- a. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
 - b. Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
 - c. Panoramic film x-rays are limited to once every 24 consecutive months.
2. Prophylaxis services (cleanings) cannot exceed two in a twelve month period.
 3. Dental sealant treatments are limited to permanent first and second molars only.
 4. Restorations are limited as follows:
 - a. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.
 - b. Composite resin or acrylic restorations in posterior teeth are optional.
 - c. Micro filled resin restorations which are non-cosmetic.
 - d. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is Dentally Necessary.
 5. Oral Surgery is limited as follows:
 - a. Surgical removal of impacted teeth is a Covered Service only when evidence of pathology exists.
 6. Endodontics: Retreatment of root canals is a Covered Service only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of sil-

ver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a Covered Service.

7. Periodontics: Periodontal scaling and root planing and subgingival curettage is limited to five quadrant treatments in any 12 consecutive months.
8. Crowns and Fixed Bridges. Five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction.

Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

- a. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the Dental Plan Administrator.
- b. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- c. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- d. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

- a. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
 - b. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
 - c. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
 - d. Fixed bridges are optional when provided in connection with a partial denture on the same arch.
 - e. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
9. Removable Prosthetics.
- a. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:
 - i. Partial dentures are not to be replaced within 36 consecutive months, unless
 - 1) it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
 - 2) the denture is unsatisfactory and cannot be made satisfactory.
 - ii. Benefits for partial dentures are limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the Dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
 - iii. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
 - iv. Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relines or repair.
 - v. Benefits for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the Dentist, the applicant will be responsible for all additional charges.
 - b. Office or laboratory relines or rebases are limited to one per arch in any 12 consecutive months.
 - c. Tissue conditioning is limited to two per denture.
 - d. Implants are considered an optional service; however, the Member, not the Plan, pays for the entire cost.
 - e. Stayplates are a Covered Service only when used as anterior space maintainers for children.

VII. SERVICE AREA AND ELIGIBILITY

SERVICE AREA

The Service Area of this Plan is identified in the Dental HMO Dental Provider Directory. You and your eligible Dependents must live or work in the Service Area identi-

fied in those documents to enroll in this Plan and to maintain eligibility in this Plan.

ELIGIBILITY

This Dental HMO Plan provides pediatric oral care coverage to meet the essential health benefits requirements of the Affordable Care Act. Benefits are provided only to Members under the age of 19.

To enroll and continue enrollment, a Subscriber must be an eligible Employee and meet all of the eligibility requirements for coverage established by the SHOP. To learn about the eligibility requirements for this dental Plan, please contact the SHOP or the Subscriber's Employer. Eligibility determinations made by the SHOP can be appealed.

An Employee or the Employee's Dependents may enroll when newly qualified as an eligible Employee or during the Employer's annual Open Enrollment Period. Under certain circumstances, an Employee and Dependents may qualify for a Special Enrollment Period. Other than the initial opportunity to enroll, the Employer's annual Open Enrollment period, or a Special Enrollment Period, an Employee or Dependent may not enroll in this dental program offered by the Employer through the SHOP

Please see the definition of Late Enrollee and Special Enrollment Period in the Definitions section for details on these rights. For additional information on enrollment periods, please contact the SHOP or Blue Shield.

Dependent children of the Subscriber, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be eligible immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days, an application must be received by the SHOP within 60 days from the date of birth, adoption or placement for adoption. If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both. Please contact the SHOP to determine what evidence needs to be provided to enroll a child.

Because eligibility to enroll in this Plan is based on the Employer's participation in the SHOP, coverage under this Plan will terminate when the employer ceases to be an Eligible Employer. Employees will receive notice of this termination from the SHOP before it becomes effective, and, at that time, will be provided with information about other potential sources of coverage, including access to individual coverage through Covered California.

Subject to the requirements described under the Continuation of Group Coverage provision in this Evidence of Coverage, if applicable, an Employee and his or her Dependents will be eligible to continue group coverage

under this dental Plan when coverage would otherwise terminate.

EFFECTIVE DATE OF COVERAGE

Blue Shield will notify the eligible Employee of the effective date of coverage for the Employee and his or her Dependents. Coverage starts at 12:01 a.m. Pacific Time on the effective date.

Dependents may be enrolled within 31 days of the Employee's eligibility date to have the same effective date of coverage as the Employee. If the Employee or Dependent is considered a Late Enrollee, coverage will become effective the earlier of 12 months from the date a written request for coverage is made or at the Employer's next Open Enrollment Period. The SHOP will not consider applications for earlier effective dates unless the Employee or Dependent qualifies for a Special Enrollment Period.

In general, if the Employee or Dependents are Late Enrollees who qualify for a Special Enrollment Period, and the Premium payment is delivered or postmarked within the first 15 days of the month, coverage will be effective on the first day of the month after receipt of payment. If the Premium payment is delivered or postmarked after the 15th of the month, coverage will be effective on the first day of the second month after receipt of payment.

However, if the Late Enrollee qualifies for a Special Enrollment Period as a result of a birth, adoption, guardianship, marriage or Domestic Partnership and enrollment is requested by the Employee within 60 days of the event, the effective date of enrollment will be as follows:

- 1) For the case of a birth, adoption, placement for adoption, or guardianship, the coverage shall be effective on the date of birth, adoption, placement for adoption or court order of guardianship.
- 2) For marriage or Domestic Partnership the coverage effective date shall be the first day of the month following the date the request for special enrollment is received.

PREPAYMENT FEE (PREMIUMS OR DUES)

The monthly Premiums for a Subscriber and any enrolled Dependents are stated in the Contract. The SHOP will provide information regarding when the Premiums are due and when payments must be made for coverage to remain in effect.

All Premiums required for coverage for the Subscriber and Dependents will be paid by the Employer to the SHOP, and the SHOP will forward the Premiums to Blue Shield. Any amount the Subscriber must contribute is set by the Employer. The Employer's rates will remain the same during the Contract's term; the term is the 12-month period beginning with the Eligible Employer's effective date of

coverage. The Employer will receive notice of changes in Premiums at least 60 days prior to the change. The Employer will notify the Subscriber immediately.

A Subscriber's contribution may change during the contract term (1) if the Employer changes the amount it requires its Employees to pay for coverage; (2) if the Subscriber adds or removes a Dependent from coverage; (3) if a Subscriber moves to a different geographic rating region, or (4) if a Subscriber joins the Plan at a time other than during the annual Open Enrollment Period. Please check with the SHOP or the Employer on when these contribution changes will take effect.

VIII. DUPLICATE COVERAGE, REDUCTIONS - THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

LIMITATIONS FOR DUPLICATE COVERAGE

When you are eligible for Medi-Cal

Medi-Cal always provides benefits last.

When you are a qualified veteran

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

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Blue Shield group plan will equal, but not exceed, what Blue Shield or a 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's or a contracted Dental Plan Administrator's Allowed Amount).

Contact the Member Services department at the number shown in the "Member Services" section of this booklet if you have any questions about how Blue Shield or a contracted Dental Plan Administrator coordinates your group plan benefits in the above situations.

EXCEPTION FOR OTHER COVERAGE

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

CLAIMS AND SERVICES REVIEW

Blue Shield and a contracted Dental Plan Administrator reserve the right to review all claims and services to determine if any exclusions or other limitations apply. Blue Shield or a contracted Dental Plan Administrator may use the services of Dentist consultants, peer review committees of professional societies, and other consultants to evaluate claims.

REDUCTIONS - THIRD PARTY LIABILITY

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield or a 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 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 cover-

age, related to the illness or injury (the “Recovery”), without regard to whether the Member has been “made whole” by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The Member is required to:

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

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

COORDINATION OF BENEFITS

Coordination of Benefits is designed to provide maximum coverage for required Dental Care Services at the lowest cost by avoiding excessive payments.

When a person who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for dental expenses, such person will not be permitted to make a “profit” on a disability by collecting Benefits in excess of actual value or cost during any calendar year.

Instead, payments will be coordinated between the plans in order to provide for “allowable expenses” (these are the expenses that are incurred for Dental Care Services covered under at least one of the plans involved) up to the maximum Benefit value or amount payable by each plan separately.

If the Member is also entitled to Benefits under any of the conditions as outlined under the “Limitations for Duplicate Coverage” provision, Benefits received under any such condition will not be coordinated with the Benefits of this Plan.

The following rules determine the order of Benefit payments:

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

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

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

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

2. Notwithstanding (1) above, if there is a court decree which otherwise establishes financial responsibility for

the dental or other health care expenses of the child, then the plan which covers the child as a Dependent of the parent with that financial responsibility shall determine its Benefits before any other plan which covers the child as a Dependent child.

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

1. a plan covering a patient as a laid-off or retired Employee, or as a Dependent of such an Employee, shall determine its Benefits after any other plan covering that person as an Employee, other than a laid-off or retired Employee, or such Dependent; and
2. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its Benefits after the other, then the provisions of (1) above shall not apply.

If this Plan is the primary carrier with respect to a covered person, then this Plan will provide its Benefits without reduction because of Benefits available from any other plan.

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

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

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

If payments have been made by Blue Shield in excess of the maximum amount of payment necessary to satisfy the-

se provisions, Blue Shield shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

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

For purposes of coordinating benefits the children's dental plan is the secondary dental benefit plan. Children's claims should be submitted to:

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

IX. GROUP CONTINUATION COVERAGE

GROUP CONTINUATION COVERAGE

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

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

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

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

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

the qualifying event such Member is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

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

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

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

 - a. the death of the Subscriber; or
 - b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
 - c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
 - d. the divorce or legal separation of the dependent spouse from the Subscriber or termination of the domestic partnership; or
 - e. the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
 - f. a dependent child's loss of dependent status under this Plan.
3. For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's dependent spouse and dependent children, when the employer files for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4. Such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1. With respect to COBRA enrollees

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

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

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under this Plan.

The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

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

2. With respect to Cal-COBRA enrollees

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

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

When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under

this Plan. The Member must then give Blue Shield notice in writing of the Member's election of continuation coverage within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage and (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

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

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

Duration and Extension of Continuation of Group Coverage

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

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

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

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

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

Notification Requirements

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

to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield at least 30 days before COBRA termination.

Payment of Dues

Dues for the Member continuing coverage shall be 102 percent of the applicable group dues rate if the Member is a COBRA enrollee or 110 percent of the applicable group dues rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be 150 percent of the applicable group dues rate.

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

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

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

Effective Date of the Continuation of Coverage

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

Termination of Continuation of Group Coverage

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

1. discontinuance of this Group Dental Service Contract (if the Employer continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer or to Blue Shield of California as applicable. Coverage will end as of the end of the period for which dues were paid;

3. the Member becomes covered under another group health plan that does not include a Pre-existing Condition exclusion or limitation provision that applies to the Member;
4. the Member becomes entitled to Medicare;
5. the Member no longer resides in Blue Shield's Service Area;
6. the Member commits fraud or deception in the use of the Services of this Plan.

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

CONTINUATION OF GROUP COVERAGE FOR MEMBERS ON MILITARY LEAVE

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

X. TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS

Except as specifically provided under the Continuation of Group Coverage provision, if applicable, there is no right to receive Benefits of this dental Plan following termination of a Member's coverage.

Cancellation at Member Request

The Member can cancel his or her coverage, including as a result of the Member obtaining other minimum essential coverage, with 14 days' notice to the SHOP or Blue Shield. If coverage is terminated at a Member's request, coverage will end at 11:59 p.m. Pacific Time on (a) the cancellation date specified by the Member if the Member gave 14 days' notice; (b) 14 days after the cancellation is requested, if the Member gave less than 14 days' notice; or (c) a date Blue Shield specifies if the Member gave less than 14 days' notice and the member requested an earlier

termination effective date. If the Member is newly eligible for Medi-Cal, Children's Health Insurance Program or the Basic Health Plan (if a Basic Health Plan is operating in the service area of Covered California), the last day of coverage is the day before such coverage begins.

Cancellation of Member's Enrollment by SHOP or Blue Shield

The SHOP or Blue Shield may cancel a Member's coverage in this dental Plan in the following circumstances:

- 1) The Member is no longer eligible for coverage in this dental Plan.
- 2) Non-payment of Premiums by the Employer for coverage of the Member.
- 3) Termination or decertification of this dental Plan.
- 4) The Subscriber changes from one dental plan to another during the annual Open Enrollment Period or during a Special Enrollment Period.

Blue Shield may cancel the Subscriber and any Dependent's coverage for cause for the following conduct; cancellation is effective immediately upon giving written notice to the Subscriber and Employer:

- 1) Providing false or misleading material information on the enrollment application or otherwise to the SHOP, Employer or Blue Shield; see the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision;
- 2) Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or
- 3) Obtaining or attempting to obtain Covered Services under the Group Dental Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

If the Employer does not meet the applicable eligibility, participation and contribution require-

ments of the Contract, Blue Shield will cancel this coverage after 30 days' written notice to the Employer.

Any Premiums paid to Blue Shield for a period extending beyond the cancellation date will be refunded to the Employer. The Employer will be responsible to Blue Shield for unpaid Premiums prior to the date of cancellation.

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

See the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact.

Cancellation By The Employer

This dental Plan may be cancelled by the Employer at any time provided written notice is given to the SHOP, all Employees and Blue Shield to become effective upon receipt, or on a later date as may be specified by the notice.

Cancellation for Employer's Non-Payment of Premiums

Blue Shield or the SHOP may cancel this dental Plan for non-payment of Premiums. If the Employer fails to pay the required Premiums when due, coverage will terminate pursuant to the rules established by the SHOP. The Employer will be liable for all Premiums accrued while this coverage continues in force including those accrued during the grace period. Blue Shield will mail the Employer a Cancellation Notice (or Notice Confirming Termination of Coverage). The Employer must provide enrolled Employees with a copy of the Notice Confirming Termination of Coverage.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind the Contract for fraud or intentional misrepresentation of material fact by the Employer, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representa-

tive. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice to the Employer prior to any rescission.

In the event the contract is rescinded or cancelled, either by Blue Shield or the Employer, it is the Employer's responsibility to notify each enrolled Employee of the rescission or cancellation. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

Date Coverage Ends

Coverage for a Subscriber and all of his or her Dependents ends at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Employer Group Dental Service Contract is discontinued, (2) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and the Employer, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer (see Cancellation for Non-Payment of Premiums), or (4) the last day of the month following the month in which notice is sent by the SHOP that the Subscriber and Dependents are ineligible for coverage in the SHOP except as provided below.

Even if a Subscriber remains covered, his Dependents' coverage may end if a Dependent become ineligible. A Dependent spouse becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber; coverage ends on the last day of the month in which the Dependent spouse became ineligible. A Dependent Domestic Partner becomes ineligible upon termination of the domestic partnership; coverage ends on the last day of the month in which the Domestic Partner becomes ineligible. A Dependent child who reaches age 19 becomes ineligible for this plan on the last day of the calendar month he or she turns 19. Prior to a dependent child turning 19, Blue Shield of California will send out a notice with a list of available options to ensure there is continuity of coverage.

In addition, if a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 60 days following that Dependent's birth or placement for adoption, Benefits under this dental Plan for that child will end on the 31st day after the birth or placement for adoption at 11:59 p.m. Pacific Time.

If the Subscriber ceases work because of retirement, disability, leave of absence, temporary layoff, or termination, he or she should contact the Employer or contact the SHOP for information on options for continued group coverage or individual options.

If the Employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), a Subscriber's payment of Premiums will keep coverage in force for such period of time as specified in such Act(s). The Employer is solely responsible for notifying their Employee of the availability and duration of family leaves.

Reinstatement

If the Subscriber had been making contributions toward coverage for the Subscriber and Dependents and voluntarily cancelled such coverage, he or she should contact the Employer regarding reinstatement options. If reinstatement is not an option, the Subscriber may have a right to re-enroll if the Subscriber or Dependents qualify for a Special Enrollment Period. The Subscriber or Dependents may also enroll during the annual Open Enrollment Period. Enrollment resulting from a Special Enrollment Period or annual Open Enrollment Period is not reinstatement and may result in a gap in coverage.

PLAN CHANGES

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

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

XI. MEMBER SERVICES AND GRIEVANCE PROCESS

MEMBER SERVICES

If you have a question about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may call your Dental Member Services Department at:

In California: 1-800-585-8111

Outside California: 1-800-323-7201

Member Services can answer many questions over the telephone.

You may write to:

Dental Plan Administrator
Dental Member Services
425 Market St., 12th Floor
San Francisco, CA 94105.

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

GRIEVANCE PROCESS

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

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

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

1-800-585-8111

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 Services section for information on the expedited decision process.

XII. OTHER PROVISIONS

DEPARTMENT OF MANAGED HEALTH CARE REVIEW

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at 1-800-585-8111 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 health or utilization of Benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

PUBLIC POLICY PARTICIPATION PROCEDURE

This procedure enables you to participate in establishing public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

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

At least one third of the Board of Directors of Blue Shield is composed of Subscribers who are not employees, providers, sub-contractors or group contract brokers and who do not have financial interests in Blue Shield.

The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Telephone: (415) 229-5065

Please follow the following procedure:

1. Your recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of your letter.
2. Your name, address, phone number, Subscriber number, and group number should be included with each communication.
3. The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter.
4. Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within 10 business days after the minutes have been approved.

GRACE PERIOD

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

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

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

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

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

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

Correspondence Address:

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

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

ACCESS TO INFORMATION

Blue Shield of California may need information from medical or dental providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Contract. You agree that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. You agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in your possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed

without your consent, except as otherwise permitted by law.

NON-ASSIGNABILITY

Benefits of this Plan are not assignable.

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

PLAN PROVIDER NETWORK

A contracted Dental Plan Administrator has established a network of Dental Providers and other dental health professionals in your Service Area.

The Dental Provider(s) you and your Dependents select will provide telephone access 24 hours a day, seven days a week so that you can obtain assistance and prior approval of necessary Dental Care Services. The Directory of Dental Providers in your Service Area indicates their location and phone numbers.

INDEPENDENT CONTRACTORS

Plan Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions of any person receiving or providing Services, including any Dentist, Physician, Hospital, or other Provider or their employees.

XIII. DEFINITIONS

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

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

Allowed Amount – the amount a Plan Dentist agrees to accept as payment from a contracted Dental Plan Administrator or the billed amount for non-Plan dentists.

Authorization – the procedure for obtaining the Plan's prior approval for all Services provided to Members under the Contract other than your Dental Provider and Emergency Services.

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

Calendar Year – a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. on January 1 of the next year.

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

Copayment – the amount that a Member is required to pay for specific Covered Services.

Cosmetic Procedure – any surgery, service, appliance, or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasing or unsightly.

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

Dental Care Services – Necessary treatment on or to the teeth or gums whether or not caused by accidental injury, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

Dental Center – means a Dentist or a dental practice (with one or more Dentists) which has contracted with a contracted Dental Plan Administrator to provide dental care Benefits to Members and to diagnose, provide, refer, supervise, and coordinate the provision of all Benefits to Members in accordance with this Contract.

Dental Provider (Plan Provider) – means a Dentist or other provider appropriately licensed to provide Dental Care Services who contracts with a Dental Center to provide Benefits to Plan Members in accordance with their Dental Services Contract.

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

1. Services which are of Dental Necessity include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards and which 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 provide; 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 of California has contracted with a contracted 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 Plan Dentists and Dental Centers.

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

Dependent –

1. a Subscriber's legally married spouse who is:
 - a. not covered for Benefits as a Subscriber; and
 - b. not legally separated from the Subscriber;or,
2. a Subscriber's Domestic Partner, who is not covered for Benefits as a Subscriber;
- or,
3. a child of, adopted by, or in legal guardianship of the Subscriber, spouse or Domestic Partner, who is unmarried and is not in a domestic partnership. This category includes any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber and who is less than 19 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by the Plan as a dependent and has maintained membership in accordance with the contract.

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

Domestic Partner – an individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

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

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

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.

Employee -- an individual employed by an employer who has been deemed eligible by the SHOP and who has been offered dental insurance coverage by such Eligible Employer through the SHOP.

Employer (Contractholder) – a small employer that has been deemed eligible by the SHOP and elects to make, at a minimum, all full-time employees of such employer eligible for one or more dental plans in the small group market offered through a SHOP.

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

Employer (Contractholder) – any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 1 employee and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

Endodontics – Dental Care Services specifically related to necessary procedures for treatment of disease of the pulp chamber and pulp canals, not requiring hospitalization.

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

Group Dental Service Contract (Contract) – the Contract issued by Blue Shield to the Contractholder that establishes the Benefits which Members are entitled to receive from the Plan.

Member – either a Subscriber or Dependent.

Open Enrollment Period - the period each year established by the Employer during which an eligible Employee

or Dependent may enroll or change coverage in this dental plan through the SHOP.

Oral Surgery – Dental Care Services specifically related to the diagnosis and the surgical and adjunctive treatment of diseases, injuries and defects of the mouth, jaws and associated structures.

Orthodontics – Dental Care Services specifically related to necessary Services for the treatment for malocclusion and the proper alignment of teeth.

Palliative Treatment – Therapy designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.

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

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

Physician – an individual licensed and authorized to engage in the practice of medicine (M.D.) or osteopathy (D.O.).

Plan – the Blue Shield Dental Plan.

Plan Dentist – a Dental Center, Plan Specialist, or other Dental Provider who has an agreement with a contracted Dental Plan Administrator to provide Plan Benefits to Members.

Plan Specialist – a Dentist who is licensed or authorized by the State of California to provide specialized Dental Care Services as recognized by the appropriate specialty board of the American Dental Association and who has an agreement with a contracted Dental Plan Administrator to provide Covered Services to Members on referral by Dental Provider.

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.

Service Area – that geographic area served by the Plan.

SHOP -- the Small Business Health Option Program (“SHOP”) operated by Covered California through which an Eligible Employer can provide its employees and their Dependents with access to one or more dental plans.

Special Enrollment Period – a period during which an individual who experiences certain qualifying events may enroll in, or change enrollment in, this dental plan through the SHOP outside of the initial and annual Open Enrollment Periods. An eligible Employee or an Employee's

Dependent has a 60-day Special Enrollment Period if any of the following occurs:

- 1) An Employee or Dependent loses minimum essential coverage for a reason other than failure to pay Premiums on a timely basis.
- 2) An Employee or Dependent has lost or will lose coverage under another employer dental benefit plan as a result of (a) termination of his or her employment; (b) termination of employment of the individual through whom he or she was covered as a Dependent; (c) change in his or her employment status or of the individual through whom he or she was covered as a Dependent, (d) termination of the other plan's coverage, (e) exhaustion of COBRA or Cal-COBRA continuation coverage, (f) cessation of an Employer's contribution toward his or her coverage, (g) death of the individual through whom he or she was covered as a Dependent, or (h) legal separation, divorce or termination of a Domestic Partnership.
- 3) A Dependent is mandated to be covered as a Dependent pursuant to a valid state or federal court order. The dental benefit plan shall enroll such a Dependent child within 60 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.
- 4) An Employee or Dependent who was eligible for coverage under the Healthy Families Program or Medi-Cal has lost coverage as a result of the loss of such eligibility.
- 5) An Employee or Dependent who becomes eligible for the Healthy Families Program or the Medi-Cal premium assistance program and requests enrollment within 60 days of the notice of eligibility for these premium assistance programs.
- 6) An Employee who declined coverage, or an Employee enrolled in this plan, subsequently acquires Dependents through marriage, establishment of Domestic Partnership, birth, adoption or placement for adoption.
- 7) An Employee's or Dependent's enrollment or non-enrollment in a dental plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the SHOP, Covered California, HHS, or any of their instrumentalities as evaluated and determined by Covered California. In such cases, Covered California may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.
- 8) An Employee or Dependent adequately demonstrates to the SHOP or Covered California that the dental

plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the Employee or Dependent.

- 9) An Employee or Dependent gains access to new dental plans as a result of a permanent move.
- 10) An Employee or Dependent demonstrates to the SHOP or Covered California, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as Covered California may provide.
- 11) An Employee or Dependent has been released from incarceration.
- 12) An Employee or Dependent was receiving services from a contracting provider under another dental benefit plan, as defined in Section 1399.845 of the Health & Safety Code or Section 10965 of the Insurance Code, for one of the conditions described in California Health & Safety Code Section 1373.96(c) and that provider is no longer participating in the dental benefit plan.
- 13) An Employee or Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.
- 14) An Employee or Dependent is a member of an Indian tribe which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, as described in Title 25 of the United States Code Section 1603.
- 15) An Employee or Dependent qualifies for continuation coverage as a result of a qualifying event, as described in the Group Continuation Coverage section of this Evidence of Coverage.

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

Surcharge – an additional fee which is charged to a Member for Dental Care Service which is not provided for in the Dental Services Contract or disclosed in the Evidence of Coverage.

Total Disability (or Totally Disabled) —

1. in the case of an Employee or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of

the individual's station in life and physical and mental capacity;

2. in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

Treatment in Progress – Partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken. Ongoing orthodontic cases are not considered Treatment in Progress under this definition.

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 Օստայրություններ: Պոք կարող եք թարգման և երբ քերել և փաստաթղթերը ընթերցել սալ և եզ համար հայերեն լեզվով: Օգնության համար մեզ գանգադարեք ևեր ինքնության (ID) սոմսի 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 چانی مربوط به زبان. می‌توانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برابن خوانده شود. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما فید شده است و با این شماره 1-866-346-7198 تماس بگیرید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਆਰੀਏ 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

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាសងកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

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

Cov Key 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 pab ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Hmong

Customer Service
1-888-702-4171

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

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

Blue Shield of California
Periodontal Coverage for Women During Pregnancy
425 Market Street, 12th Floor
San Francisco, CA 94105

Please direct correspondence to:

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

