

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

GROUP DENTAL SERVICE CONTRACT

CHILDREN'S DENTAL PPO PLAN 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 Lombardo".

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

Group Number: **[XYZ999]**

Original Effective Date: **[January 1, 2015]**

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

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 of 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 ADVANCE NOTIFICATION

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 Dues/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.

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.

PART VI. CANCELLATION/REINSTATEMENT/GRACE PERIOD

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 Contract:

A. Choice of Providers

A Member may select any licensed Dentist or Oral Surgeon to provide Covered Services hereunder, including such providers outside of California that meet similar requirements.

A Directory of Participating Dentists is available to all Subscribers by calling Dental Customer Service at 1-888-702-4171 or writing to:

Dental Plan Administrator
Dental Customer Service
425 Market Street, 12th Floor
San Francisco, CA 94105

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, Deductible, and Copayment, 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 Customer Service 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. Reimbursement to Employees

An Employee, with respect to himself or any of his covered Dependents, is entitled to payment directly from Blue Shield or a contracted Dental Plan Administrator for Services which are a Benefit of this contract when he is ineligible for Service payments because (i) he has failed to notify a Participating Dentist of his Blue Shield membership, (ii) he has selected a Non-Participating Dentist, or (iii) he has received Services which are Benefits while he is outside of the State of California. Requests for payment must be submitted to a contracted Dental Plan Administrator within 1 year after the month in which Services were provided.

In order to receive such Benefits, the Subscriber or the Non-Participating Dentist must complete a claim form and submit it to a contracted Dental Plan Administrator. Claim forms may be obtained from the Contractholder, from a contracted Dental Plan Administrator, or from any Blue Shield office.

However, if an Employee or any of his covered Dependents is receiving Services from a Participating Dentist as of the date that such provider's contract with a contracted Dental Plan Administrator is terminated, the Employee's responsibility to that provider for Services rendered subsequent to that termination date shall be no greater than it was for Services rendered immediately prior to that termination date, until the first to occur of the following:

1. the date that the Services being rendered by such provider are completed;
2. the date that a contracted Dental Plan Administrator makes reasonable and dentally appropriate provision for the assumption of such Services by another contracting provider;
3. the date that coverage for such Member is terminated.

Participating Providers submit claims for payment after their services have been received. You or your Non-Participating Providers also submit claims for payment after services have been received.

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

M. 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 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 or Schedules of Benefits 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 or Schedules of Benefits and are included as part of this Contract.

Blue Shield of California Children's Dental PPO Plan for SHOP

Summary of Benefits

Group

An independent member of the Blue Shield Association

Blue Shield of California Children's Dental PPO 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.

	Participating Dentists	Non-Participating Dentists
Calendar Year Deductible^{1,2}	\$65 per Member/\$130 per Family (applies to all Covered Services except Diagnostic and Preventive Care)	\$65 per Member/\$130 per Family (applies to all Covered Services except Diagnostic and Preventive Care)
Calendar Year Benefit Maximum	No maximum	\$1,000 per Member
Calendar Year Out-of-Pocket Maximum^{1,2}	\$350 per Member/ \$700 per Family	No maximum

Covered Services	Member Copayments	
	Participating Dentists	Non-Participating Dentists
Diagnostic and Preventive Care Services⁶	No charge	20%
Restorative Services²	20%	30%
Oral surgery^{2,3}	50%	50%
Endodontics^{2,3}	50%	50%
Periodontics^{2,3}	50%	50%
Crowns and Fixed Bridges^{2,3}	50%	50%
Removable Prosthetics^{2,3}	50%	50%
Orthodontics^{2,3,4}	50%	50%
Other Benefits²	20%	30%

Footnotes:

- For families with two (2) or more children enrolled in this pediatric dental plan:
 - the Calendar Year Deductible is limited to \$130 for all children enrolled (\$65 per child, deductible not to exceed \$130); and,
 - the Calendar Year Out-of-Pocket Maximum is limited to \$700 for all children enrolled (\$350 per child, maximum not to exceed \$700).
- The Calendar Year Deductible and Coinsurance amounts for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Coinsurance amounts 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 for that child or children. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum.
- There are no waiting periods for major & orthodontic services.

Blue Shield of California Children's Dental PPO for SHOP

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 (see list below). Pre-certification for all orthodontia evaluation and services is required.

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins 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.
- 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).

5. For Covered Services rendered by Non-Participating Dentists, the Member is responsible for all charges above the Allowable Amount.
6. 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 PPO for SHOP

Covered Services

The following Benefits are covered with a Coinsurance (after any applicable Calendar Year Deductible has been met). The Member's Coinsurance is a percentage of the Allowable Amount, as defined in 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 PPO Plan for SHOP

Evidence of Coverage

Group

Evidence of Coverage

Blue Shield of California Children's Dental PPO Plan for SHOP*

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 in the dental Plan.

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

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

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

This booklet constitutes only a summary of the Dental Care Plan. The group Plan contract must be consulted to determine the exact terms and conditions of coverage.

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

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

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

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

IMPORTANT

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

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

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

IMPORTANT

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

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INTRODUCTION TO THE BLUE SHIELD OF CALIFORNIA CHILDREN'S DENTAL PPO PLAN

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.

If you have questions about your Benefits, contact Blue Shield's Dental Customer Service before dental services are received.

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.

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.

Before Obtaining Dental Services:

You are responsible for assuring that the Dentist you choose is a Participating Dentist. Note: A Participating Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dentist, in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located in your area can be obtained by contacting a contracted Dental Plan Administrator at 1-888-702-4171. You may also access a list of Participating Dentists through Blue Shield's Internet site located at <http://www.blueshieldca.com>. You are also responsible for following the Precertification of Dental Benefits Program which includes obtaining or assuring that the Participating or Non-Participating Dentist obtains Precertification of Benefits.

NOTE: A contracted Dental Plan Administrator will respond to all requests for precertification and prior authorization within 5 business days from receipt of the request. For emergency services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a contracted Dental Plan Administrator will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

Failure to meet these responsibilities will not necessarily result in the denial of Benefits. However, by following the Precertification process both you and your Dentist will

know in advance which services are covered and the Benefits that are payable.

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

PARTICIPATING DENTISTS

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

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

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

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

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

The Member should contact Customer Services if the Member needs assistance locating a provider in the Member's Service Area. The Plan will review and consider a Member's request for services that cannot be reasonably obtained in network. If a Member's request for services from a Non-Participating Dental Provider is approved at an in-network benefit level, the Plan will pay for Covered Services at a Participating Provider level.

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

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 network of Participating Dentists. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES

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

ELIGIBILITY AND ENROLLMENT

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.

DEDUCTIBLE

CALENDAR YEAR DEDUCTIBLE

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

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

PRECERTIFICATION OF DENTAL BENEFITS PROGRAM

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

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

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

If your Plan provides Special Implant Benefits, failure to obtain Precertification/prior authorization of these Benefits will result in a denial of Benefits. For all other Benefits, failure to obtain Precertification of Benefits will not necessarily result in a denial of Benefits. If the Precertification

process is not followed, a contracted Dental Plan Administrator will still determine payment by taking into account alternative procedures, Services or materials for the dental condition based on professionally recognized standards of dental practice. However, by following the Precertification process both you and your Dentist will know in advance which services are covered and the Benefits that are payable.

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

Example:

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

PAYMENT

PAYMENT AND SUBSCRIBER COINSURANCE RESPONSIBILITIES

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

The maximum per Member, per Calendar Year amount payable by Blue Shield for covered Services and supplies provided by any combination of Participating and Non-Participating Dentists is listed in the Summary of Benefits which is attached to and made a part of this EOC.**

**NOTE: If your Plan provides benefits for Orthodontia, a separate Calendar Year Benefit maximum applies to Orthodontic Services. See the Summary of Benefits which is attached to and made a part of this EOC.

PARTICIPATING DENTISTS

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

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

NON-PARTICIPATING DENTISTS

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

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

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

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

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

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

Administrator and the amount collected by the covered Member for these Services.

Calendar Year Maximum Payment

The calendar year maximum for covered Services and Supplies provided by Participating Dentists and Non-Participating Dentists is specified on the Summary of Benefits.

Out-Of-Pocket Maximum

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

PRINCIPAL BENEFITS AND COVERAGES

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

IMPORTANT INFORMATION

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

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

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

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

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

Unless exceptions to the following general exclusions are specifically made elsewhere under this plan, this plan does not provide Benefits 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 or 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 silver 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.
 - a. 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:
 - i. 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.
 - ii. 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.
 - iii. 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.
 - iv. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
 - b. Fixed bridges, which are cast, porcelain

baked with metal, or plastic processed to gold, are limited as follows:

- i. 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.
 - ii. 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.
 - iii. 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.
 - iv. Fixed bridges are optional when provided in connection with a partial denture on the same arch.
 - v. 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 reline 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.

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

When you are covered by another 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 Allowable Amount).

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

EXCEPTION FOR OTHER COVERAGE

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

REDUCTIONS — THIRD PARTY LIABILITY

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

The covered Member is required to:

1. Notify Blue Shield or a contracted Dental Plan Administrator in writing of any actual or potential claim or legal action which such covered Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,

3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide a lien calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield and a 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.

TERMINATION OF BENEFITS (CANCELLATION AND RESCISSION OF COVERAGE)

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 requirements 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 representative. 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.

**LIABILITY OF SUBSCRIBERS
IN THE EVENT OF NONPAYMENT
BY BLUE SHIELD OF CALIFORNIA**

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

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

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

PREPAYMENT FEE (DUES OR PREMIUMS)

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.

PLAN CHANGES

The Benefits of this Plan, including but not limited to Covered Services, Deductible, and Coinsurance, 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.

BLUE SHIELD ONLINE

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

CHOICE OF PROVIDERS

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

FACILITIES (PARTICIPATING PROVIDERS)

The names of Participating Dentists in your area may be obtained by contacting a contracted Dental Plan Administrator at 1-888-702-4171. You may also access a list of

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

CUSTOMER SERVICE

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

1-888-702-4171

Dental Plan Administrator
Dental Customer Service
425 Market Street, 12th Floor
San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

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

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

GRIEVANCE PROCESS

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

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

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The

Subscriber may request this Form from the Dental Customer Service Department. If the Subscriber wishes, the Dental Customer Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to a contracted Dental Plan Administrator at the address provided below. The Subscriber may also submit the grievance to the Dental Customer Service Department online by visiting <http://www.blueshieldca.com>.

1-888-702-4171

Blue Shield of California
Dental Plan Administrator
425 Market Street, 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 Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

DEPARTMENT OF MANAGED HEALTH CARE REVIEW

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at 1-888-702-4171 and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site, **(<http://www.hmohelp.ca.gov>)**, has complaint forms, IMR application forms, and instructions online.

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

CONTINUATION OF GROUP COVERAGE

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

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

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

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

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

QUALIFYING EVENT

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

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

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

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

NOTIFICATION OF A QUALIFYING EVENT

1. With respect to COBRA enrollees:

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

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

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

ber's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

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

2. With respect to Cal-COBRA enrollees:

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

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

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

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

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

DURATION AND EXTENSION OF CONTINUATION OF GROUP COVERAGE

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

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue

coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

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

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

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

NOTIFICATION REQUIREMENTS

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

PAYMENT OF DUES

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

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

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

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

the correct amount within the 45-day period will disqualify the Member from continuation coverage.

EFFECTIVE DATE OF THE CONTINUATION OF COVERAGE

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

TERMINATION OF CONTINUATION OF GROUP COVERAGE

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

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

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

CONTINUATION OF GROUP COVERAGE FOR MEMBERS ON MILITARY LEAVE

Continuation of group coverage is available for Members on military leave if the Member's Employer is subject to the Uniformed Services Employment and 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.

COORDINATION OF BENEFITS

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

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

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

The following rules determine the order of benefit payments:

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

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

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

First, the plan of the parent with custody of the child; *then*, if that parent has remarried, the plan of the 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 medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of the parent with that financial responsibility

shall determine its benefits before any other plan which covers the child as a Dependent child.

3. If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:
 - a. a plan covering a patient as a laid-off or retired Employee, or as a Dependent of such an Employee, shall determine its benefits after any other plan covering that person as an Employee, other than a laid-off or retired Employee, or such Dependent; and
 - b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then the provisions of (a.) above shall not apply.

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

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

When the Plan is secondary in the order of payments, and Blue Shield of California and a contracted Dental Plan Administrator are notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, the Plan will pay the benefits that would be due as if it were the primary plan, provided that the covered Member (1) assigns to a contracted Dental Plan Administrator or Blue Shield of California the right to receive benefits from the other plan to the extent of the difference between the benefits which a contracted Dental Plan Administrator or Blue Shield of California actually pays and the amount that a contracted Dental Plan Administrator or Blue Shield of California would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with a contracted Dental Plan Administrator or Blue Shield of California in obtaining payment of benefits from the other plan, and (3) allows Blue Shield of California or a 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 the Plan in accordance with these provisions have been made by another plan, Blue Shield may pay to the other plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as benefits paid under the Plan. Blue Shield shall be fully 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 these provisions, Blue Shield shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

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

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

REIMBURSEMENT PROVISIONS

PROCEDURE FOR FILING A CLAIM

Claims for covered dental Services should be submitted on a dental claim form which may be obtained from your Employer, a contracted Dental Plan Administrator, or any Blue Shield of California office. Have your Dentist complete the form and mail it to a contracted Dental Plan Administrator Service Center shown on the last page of this booklet.

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

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

NON-ASSIGNABILITY

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

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

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

CLAIMS REVIEW

Blue Shield of California and a contracted Dental Plan Administrator reserve the right to review all claims to determine whether any exclusions or limitations apply.

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

PUBLIC POLICY PARTICIPATION PROCEDURE

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

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

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

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

Sr. Manager, Regulatory Filings
Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Phone: 1-415-229-5065

PROCEDURE

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

GRACE PERIOD

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

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

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

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

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

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

Correspondence Address:

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

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

ACCESS TO INFORMATION

Blue Shield of California may need information from medical or dental providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Contract. You agree that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. You agree to assist Blue

Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in your possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

INDEPENDENT CONTRACTORS

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

DEFINITIONS

Whenever any of the following terms are capitalized in this booklet, they will have the meaning stated below:

Allowable Amount — a contracted Dental Plan Administrator Allowance (as defined below) for the Service (or Services) rendered, or the provider's Billed Charge, whichever is less. A contracted Dental Plan Administrator Allowance is:

1. the amount a contracted Dental Plan Administrator has determined is an appropriate payment for the Service(s) rendered in the provider's geographic area, based upon such factors as a contracted Dental Plan Administrator's evaluation of the value of the Service(s) relative to the value of other Services, market considerations, and provider charge patterns; or
2. such other amount as the Participating Dentist and a contracted Dental Plan Administrator have agreed will be accepted as payment for the Service(s) rendered; or
3. if an amount is not determined as described in either (1.) or (2.) above, the amount a contracted Dental Plan Administrator determines is appropriate considering the particular circumstances and the Services rendered.

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

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

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

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

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

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

Dental Necessity (Dentally Necessary) — 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.

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

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

Dependent — the spouse or registered Domestic Partner, or child, of an eligible Employee, who is determined to be eligible and who is not independently covered as an eligible Employee or Subscriber.

- 1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.
- 2) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 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. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

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

1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
2. Both persons 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 (Premiums) — the monthly pre-payment that is made to the Plan on behalf of each Member.

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.

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 the Plan to the contractholder that establishes the Services that Subscribers and Dependents are entitled to receive from the Plan.

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

Member — either a Subscriber or an eligible Dependent.

Non-Participating Dentist — a Doctor of Dental Surgery or Doctor of Dental Medicine who has not signed a service

contract with a contracted Dental Plan Administrator to provide dental services to Subscribers.

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.

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

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

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 Employee as defined, who has been enrolled and accepted by Blue Shield of California as a member of the group contract and has maintained his or her Blue Shield of California coverage under the terms of this group contract.

Total 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.

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

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

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

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

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ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਆਰਾ ਦੇ 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 និងអាសនៈសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដៃលម្អិត បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

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

Customer Service

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