

Disclosure

Specialty DUOSM Dental Disclosure Form

An independent licensee of the Blue Shield Association

Blue Shield Life Disclosure Form:

NOTICE

This Disclosure Form is only a summary of the Plan. You have the right to review the dental Policy, which you can obtain from Blue Shield of California Life & Health Insurance Company (Blue Shield Life) upon request, to determine the terms and conditions governing your coverage

The Policy contains the terms and conditions of coverage of your Blue Shield Life dental Plan. It is your right to view the Policy prior to enrollment in the dental Plan.

Please read the Disclosure Form and Policy 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 Life provides you with a Benefit Summary summarizing key elements of the Blue Shield Life dental Plan you are being offered. This is to assist you in comparing 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 Life customer service at the address or telephone number listed in this booklet.

Dental Duo Plan

This Disclosure Form is only a summary of your dental Plan. The dental Policy, which you can obtain from Blue Shield Life, should be consulted to determine the terms and conditions governing your coverage. The dental Policy is on file with Blue Shield Life and a copy will be furnished upon request.

The Policy describes the terms and conditions of coverage of your Blue Shield Life dental Plan. It is your right to view the Policy prior to enrollment in the dental Plan.

To obtain a copy of the Policy or if you have questions about the Benefits of the Plan, please contact the customer service at 1-888-702-4171. The hearing impaired may contact customer service by calling the TTY number at 711.

Please read this Disclosure Form carefully and completely so that you understand which services are covered Dental Care Services, and the limitations and exclusions that apply to the Plan.

A benefit summary, summarizing key elements of the Blue Shield Life dental Plan you are being offered, is provided with this Disclosure Form to assist you in comparing dental Plans available to you.

IMPORTANT

If you opt to receive dental services that are not Covered Services under this Plan, a participating 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 customer service at 1-888-702-4171 or your insurance broker. To fully understand your coverage, you may wish to carefully review the Policy document you have been provided.

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

The Duo (Dental + Vision) Plan package consists of a dental Plan and a vision Plan which is offered at a package rate. This disclosure describes the Benefits of the Duo Dental Plan, the dental Plan in the Duo (Dental + Vision) Plan package.

Blue Shield Life's dental Plans are administered by a Dental Plan Administrator (DPA) which is an entity that contracts with Blue Shield Life to administer the delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield Life to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

CHOICE OF DENTISTS

With Blue Shield Life'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 amount, as payment in full for Covered Services.

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

Participating Dentists submit claims for payment after Dental Care Services have been rendered. Payments for these claims go directly to the Participating Dentist. You or your Non-Participating Provider 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.

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. This contractual arrangement may include incentives to manage all services provided to Insured Persons in an appropriate manner consistent with the Policy. If you want to know more about this payment system, contact customer service at 1-888-702-4171.

A list of Participating Dentists located in your area can be obtained by contacting customer service at 1-888-702-4171. You may also access a list of Participating Dentists through

Blue Shield Life's website located at www.blueshieldca.com.

EMERGENCY DENTAL CARE SERVICES

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

If the Insured Person is in need of emergency treatment, the Insured Person should first contact the DPA if possible, to describe the emergency and receive referral instructions. If the DPA does not have a contracted Dentist in the area, or if the Insured Person is unable to contact the DPA, the Insured Person should contact a Dentist of their choice. Emergency treatment refers only to those dental services required to alleviate pain and suffering. The Insured Person will be directly reimbursed for this treatment up to the maximum allowed under their Plan Benefits.

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

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 customer service at 1-888-702-4171. You may also access a list of Participating Dentists through Blue Shield Life's website located at www.blueshieldca.com. You are also responsible for following the Precertification of Dental Benefits Program, described in the Policy, which includes obtaining or assuring that the Participating or Non-Participating Dentist obtains precertification of Benefits.

FACILITIES

Directories of Participating Dentists are available on our website www.blueshieldca.com or by calling customer service at 1-888-702-4171.

CONTINUITY OF CARE BY A TERMINATED DENTIST

Insured Persons who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age, or who have received authorization from a now-terminated Dentist 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 Dentist who is leaving a

Dental Plan Administrator's network of Participating Dentists. Contact customer service to receive information regarding eligibility criteria and the Policy and procedure for requesting continuity of care from a terminated Dentist.

CONTINUITY OF CARE FOR NEW INSURED PERSONS BY NON-CONTRACTING PROVIDERS

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

FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES

If an Insured Person is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Insured Person 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 dental provider in the same geographic area.

UTILIZATION REVIEW

State law requires that insurers disclose to Insureds and providers the process used to authorize or deny services under the Plan.

Blue Shield Life has completed documentation of this process ("Utilization Review"), as required under Section 10123.135 of the California Insurance Code.

To request a copy of the document describing this Utilization Review process, call customer service at 1-888-702-4171.

PRINCIPAL BENEFITS AND COVERAGES

The Benefits of the Plan are listed in the Benefit Summary. Blue Shield Life payments for these services, if applicable, are also listed in the Benefit Summary.

LIMITATIONS AND EXCLUSIONS

The following is a summary of services and supplies not covered by Blue Shield Life dental Plans. For a complete list of dental coverage exclusions and limitations, please refer to the Policy/Benefit Summary for your dental Plan.

General Exclusions

Unless exceptions to the following general exclusions are specifically made elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Services not listed as covered in the Insured Person's Policy/Benefit Summary;
2. Services to be paid by the Insured Person's Blue Shield Life dental Plan;
3. Services begun prior to the patient's effective date of coverage;
4. Services performed or supplies provided in a hospital or any place other than a dental office;
5. Unnecessary, investigational, experimental, cosmetic, or elective services; services for which the prognosis is not favorable, as determined by the Dental Plan Administrator;
6. Services performed by a Close Relative or someone who lives in the Insured Person's home; services for which the Insured Person is not obligated to pay or services performed at no charge;
7. Services paid for by any governmental agency;
8. Implants, except when covered in specific Plans;
9. Vestibuloplasty, orthognathic surgery, treatment of jaw fractures or TMJ (temporomandibular joint) syndrome;
10. Treatment of congenital anomalies or developmental malformation;
11. Treatment to correct malignancies, cysts, tumors, and neoplasm;
12. Myofunctional therapy, biofeedback procedures, athletic mouth guards, precision or semi-precision attachments, denture duplication;
13. Treatment of accidental or self-inflicted injuries, including setting of fractures and dislocation; Accidental Injury means a condition or injury caused by external, violent or accidental means, rather than by dental illness (e.g. injury caused by a fall or car accident);
14. General anesthesia or intravenous or inhalation sedation, unless Medically Necessary;
15. Prescription or non-prescription drugs;
16. Replacement of appliances (dentures, space maintainers, crowns, etc.) lost or stolen within five years of installation;
17. Removal of wisdom teeth unless of Medical Necessity;
18. Any services Blue Shield Life or the Dental Plan Administrator determines not to be of Medical Necessity as defined in the Policy/Benefit Summary;

19. Temporary dental services. Charges for temporary dental services are considered an integral part of the final dental service and will not be separately payable;
 20. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances, or any other method that splints or connects teeth together;
 21. Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;
 22. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;
 23. Services and/or appliances that alter the vertical dimension, including, not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion, or abrasion, appliances or any other method;
 24. Procedures that are principally cosmetic in nature, including, but not limited to, bleaching, veneer facings, crowns, porcelain on molar crowns, personalization or characterization of crowns, bridges and/or dentures; and
 25. Charges for saliva and bacterial testing when caries management procedures D0601, D0602, and D0603 are performed.
6. Space maintainers are only eligible for Insured Persons through age 15 when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not developed, or will never develop.
 7. Sealants are only eligible for Insured Persons one per tooth per two-year period through age 11 on permanent first and second molars.
 8. Oral surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy, and crown lengthening.
 9. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the Dentist. For example, an alternate Benefit of a partial denture will be applied when there are bilaterally missing teeth or more than three teeth missing in one quadrant or in the anterior region. The ABP does not commit the Insured Person to the less costly treatment. However, if the Insured Person and the Dentist choose the more expensive treatment, the Insured Person is responsible for the additional charges beyond those allowed for the ABP.
 10. General IV or inhalation sedation is covered for the following:
 - A. Three or more surgical extractions;
 - B. One or more impactions;
 - C. Full-mouth or arch alveoloplasty;
 - D. Surgical root recovery from sinus;
 - E. Medical problem contraindicates local anesthesia; and
 - F. Children under the age of seven (7) years old.
 (General or IV sedation is not a covered Benefit for dental-phobic reasons);
 11. Restorations, crowns, inlays, and onlays are covered only if necessary to treat diseased or accidentally fractured teeth;
 12. Root canal treatment is covered one per tooth per lifetime;
 13. Root canal retreatment is covered one per tooth per lifetime;
 14. Pulpal therapy is covered through age 5 on primary anterior teeth and through age 11 on primary posterior teeth;
 15. For mucogingival surgeries, one site is equal to two consecutive teeth or bonded spaces;

General Limitations

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

1. Periodic oral exam, routine prophylaxis, fluoride treatment, bitewing X-rays (maximum of four per occurrence), and recementations (if the crown was provided by other than the original Dentist; not eligible if the Dentist is doing the recementation of service he/she provided within 12 months) are Covered Services every 6-month period;
2. Denture (complete and partial) relines and oral cancer screenings are Covered Services every 12-month period;
3. Gingival flap surgery per quad, diagnostic casts, sealants, and occlusal guards are Covered Services every 24-month period;
4. Full-mouth debridement, mucogingival surgery per area, osseous surgery per quad, gingivectomy per quad, gingivectomy per tooth, bone replacement grafts for periodontal purposes, guided tissue regeneration for periodontal purposes, full-mouth series and panoramic x-rays are Covered Services every 36-month period.
5. Single crowns and onlays, single post and core buildups, crown buildup including pins, prefabricated post and core, cast post and core in addition to crown, Complete dentures, partial dentures, fixed partial denture (bridge) pontics, fixed partial denture (bridge) abutments, abutment post and core buildups are Covered Services every five-year period.

16. Scaling and root planing are covered once for each of the four quadrants of the mouth in a 24-month period. Scaling and root planing is limited to two quadrants of the mouth per visit;
17. Cone Beam CT (D0367) is a Benefit only when placing an Implant. This procedure cannot be used for Orthodontics or Periodontics. This is a once in a lifetime Benefit and is limited to projection of upper and lower jaws only; and
18. You must be 21 or older to be eligible for dental Implant Benefits due to continued growth and development of the mid face and jaws. If there are bilaterally missing teeth or more than three (3) teeth missing in a quadrant, or more than three (3) teeth missing in the anterior region, the Insured Person will be given an alternate Benefit of a partial denture. If the Insured Person elects a different procedure, payment will be based on the partial denture Benefit.
14. Treatment exceeding 24 months except for treatment prior approved by Blue Shield Life as Medically Necessary;
15. In the event of an Insured Person's loss of coverage for any reason, if at the time of loss of coverage the Insured Person is still receiving Orthodontic treatment during the 24 month treatment period, the Insured Person and not a contracted Dental Plan Administrator will be responsible for the remainder of the cost for that treatment at the Plan Orthodontist's billed charges, prorated for the number of months remaining;
16. If the Insured Person is reinstated after cancellation, there are no Orthodontic Benefits for treatment begun prior to his or her reinstatement effective date;
17. There is a 12 month waiting period before beginning Orthodontic treatment;
18. If the Insured Person elects to use the Invisalign system, additional costs beyond what Blue Shield Life will pay for "standard" Orthodontic treatment (i.e. braces and bands) will be paid by the Insured Person;
19. Benefits for the initial placement will not exceed 20% of the lifetime maximum Benefit amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the Orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits, and procedures performed in connection with the Orthodontic treatment are all subject to the Orthodontia Coinsurance level and lifetime maximum Benefit amount; and
20. Orthodontic Benefits end at cancellation of coverage.

Specific Exclusions & Limitations

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

1. Any inlay restorations;
2. Crowns or onlays installed as multiple abutments;
3. Prosthetic appliance related to Periodontics;
4. Charges for missed appointments;
5. Alloplastic bone grafting materials;
6. Bone grafting done for socket preservation after tooth extraction or in preparation for Implants; (unless your Plan provides special Implant Benefits. Please see the Benefit Summary to determine if you have Implant Benefits.);
7. Charges for services in connection with orthodontia when rendered by a Non-Participating Dentist;
8. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
9. Treatment in progress (after banding) at inception of eligibility;
10. Surgical Orthodontics (including extraction of teeth incidental to Orthodontic treatment);
11. Treatment for TMJ (Temporomandibular Joint) disorder or dysfunction;
12. Special Orthodontic appliance, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
13. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;

PREPAYMENT FEE

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

Please call customer service at 1-888-702-4171 to discuss these options or visit www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield Life
P. O. Box 51827
Los Angeles, CA 90051-6127

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

OTHER CHARGES

Calendar Year Deductible

For dental Plans with a Calendar Year Deductible, the Deductible applies to all Covered Services and supplies furnished by Participating and Non-Participating Dentists, except as specified in the Benefit Summary. 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 Insured Person Deductible applies separately to each covered Insured Person each Calendar Year. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan.

The Calendar Year Deductible per Insured Person is listed in the Benefit Summary which is attached to and made a part of this Disclosure Form.

Payment and Subscriber Coinsurance Amount Responsibilities

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

For dental plans with a calendar year maximum payment, the maximum per Insured Person, per Calendar Year amount payable by Blue Shield Life for Covered Services and supplies provided by any combination of Participating and Non-Participating Dentists is listed in the Benefit Summary which is attached to and made a part of this Disclosure Form.

*NOTE: If your Plan provides Benefits for orthodontia, a separate Benefit maximum applies to Orthodontic services.

Out-Of-Pocket Maximum

For dental Plans with an Out-of-Pocket Maximum, the out-of-pocket maximum per Insured Person for all Covered Services and supplies furnished by Participating and Non-Participating Dentists is specified on the Benefit Summary. This amount is the most the Insured Person pays during the coverage period (usually one year) for the Insured Person's share of the cost of Covered Services. This limit helps the Insured Person plan for dental care expenses.

REIMBURSEMENT PROVISION

Procedure for Filing a Claim

Claims for covered dental services should be submitted on a dental claim form which may be obtained from the Dental Plan Administrator, at www.blueshieldca.com or any Blue Shield Life office. Have your Dentist complete the form and mail it to Dental Plan Administrator customer service.

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

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

Renewal Provisions

The Policy shall be renewed upon receipt of pre-paid Dues. Renewal is subject to Blue Shield Life's right to amend the Policy. Any change in Dues or Benefits, including but not limited to Covered Services, Deductible, Coinsurance, and annual maximum amounts, are effective after 60 days' notice to the Insured Person's address of record with Blue Shield Life.

ENTIRE POLICY: CHANGES

The Policy, including the appendices, constitutes the entire agreement between parties. Any statement made by an Insured Person shall, in the absence of fraud, be deemed a representation and not a warranty. No change in the Policy shall be valid unless approved by a corporate officer of Blue Shield Life and a written endorsement issued. No agent has authority to change the Policy or to waive any of its provisions.

The Benefits of this Plan, including but not limited to Covered Services, Deductible, Coinsurance amount, and Calendar Year maximums, are subject to change at any time. Blue Shield Life 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. There is no vested right to obtain Benefits.

TERMINATION OF BENEFITS

There is no right to receive Benefits for services provided following termination of the contract. The Contract is issued for a one year period.

Blue Shield Life may terminate you or your Dependent's coverage for cause immediately upon written notice to you for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to or Blue Shield Life
2. Permitting use of your Subscriber identification card by someone other than yourself or your Dependents to obtain services;
3. Obtaining or attempting to obtain services under the Contract by means of false, materially misleading, or fraudulent information, acts or omissions;

4. Abusive or disruptive behavior which: (1) threatens the life or well-being of Blue Shield Life personnel and providers of services, or, (2) substantially impairs the ability of Blue Shield Life to arrange for services to the Insured Person, or, (3) substantially impairs the ability of providers of service to furnish services to the Insured Person or to other patients.

If written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield Life within the 31 days following that Dependent's effective date of coverage, Benefits under the Plan will be terminated on the 31st day at 11:59 P.M. Pacific Time.

GRACE PERIOD

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

BLUE SHIELD LIFE ONLINE

Blue Shield Life's website is located at www.blueshieldca.com. Insured Persons with Internet access and a Web browser may view and download healthcare information.

GRIEVANCE PROCESS

Blue Shield Life has established a grievance procedure for receiving, resolving, and tracking Insured Persons' grievances with Blue Shield Life. For more information on this process, see the Grievance Process section in the COI.

CALIFORNIA DEPARTMENT OF INSURANCE REVIEW

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured Person or his or her provider.

If you have a complaint against Blue Shield of California Life & Health Insurance Company, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8 a.m. – 5 p.m., Monday – Friday

(excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013, or through the website www.insurance.ca.gov.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

Blue Shield Life 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 Life will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield Life's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling customer service at 1-888-702-4171, or by accessing Blue Shield Life's website located at www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield Life 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 Life Privacy Official

P.O. Box 272540

Chico, CA 95927-2540

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

DEFINITIONS

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

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

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.

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

Benefits (Covered Services) – those services which an Insured Person is entitled to receive pursuant to the dental Policy.

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

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

Coinsurance – the percentage of the Allowable Amount that an Insured Person is required to pay for specific Covered Services after meeting any applicable Deductible.

Covered Services (Benefits) – those services which an Insured Person is entitled to receive pursuant to the terms of the dental Policy.

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

Dental Plan Administrator (DPA) – a DPA is an entity that contracts with Blue Shield Life to administer the delivery of dental services through a network of Participating Dentists.

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

Dependent –

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

- a. a Resident of California (unless a full-time student); and
 - b. not covered for Benefits as a Subscriber; and
 - c. not legally separated from the Subscriber; or,
2. a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, who is unmarried and is not in a domestic partnership. This category includes any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber and who is less than 26 years of age and who has been enrolled and accepted by Blue Shield Life as a Dependent and has maintained membership in accordance with the Policy.

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

3. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent child will be continued upon the following conditions:
 - a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
 - b. the Subscriber, spouse, or Domestic Partner must submit to Blue Shield Life a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield Life's request; and
 - c. thereafter, certification of continuing disability and dependency from a Physician is submitted to Blue Shield Life on the following schedule:
 - (1) within 24 months after the month when the Dependent would otherwise have been terminated; and
 - (2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

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

- 1) Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;
- 2) The partners have chosen to share an intimate and committed relationship of mutual caring;

3) The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited; and

4) Both partners are capable of consenting to the domestic partnership.

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

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

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

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

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).

Insured Person – either a Subscriber or an eligible Dependent.

Medical Necessity (Medically Necessary) – Benefits are provided only for services that are Medically Necessary.

1. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted national and California dental standards to treat illness, injury, or dental condition, and which are:
 - a. Consistent with Blue Shield Life’s dental policies that ensure decisions based on Medical Necessity are supported by clinical principles and processes. Such policies are available upon request;
 - b. Consistent with the symptoms or diagnosis;
 - c. Not furnished primarily for the convenience of the patient, the attending Dentist or other provider;
 - d. Furnished at the most appropriate level of care which can be provided safely and effectively to the patient; and
 - e. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Insured Person’s illness, injury or dental condition.

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.

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

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

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

Policy — an insurance policy issued by Blue Shield Life to the Insured Person.

Plan – the dental plan indicated on the cover of this document.

Premiums – the monthly pre-payment that is made to the Plan on behalf of each Insured Person.

Subscriber – an individual who has been enrolled and accepted by Blue Shield Life as an Insured Person of the Policy and has maintained his or her Blue Shield Life coverage under the terms of this Policy.