Disclosure

Dental INO Plan Disclosure Form

blue of california

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Blue Shield Life Disclosure Form:

NOTICE

This Disclosure Form is only a summary of the Plan. You have the right to review the Group Dental Policy, which you can obtain from your Employer upon request, to determine the terms and conditions governing your coverage

The Certificate of Insurance contains the terms and conditions of coverage of your Blue Shield of California Life & Health Insurance Company (Blue Shield Life) dental Plan. It is your right to view the Certificate of Insurance prior to enrollment in the dental Plan.

Please read the Disclosure Form and Certificate of Insurance 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 Matrix summarizing key elements of the Blue Shield Life 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 Life Customer Service at the address or telephone number listed at the back of this booklet.

NOTICE

THIS IN-NETWORK ONLY DENTAL PLAN DOES NOT PAY BENEFITS TO NON-NETWORK PROVIDERS EXCEPT FOR EMERGENCY BENEFITS

Dental INO Plan

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

The Certificate of Insurance (COI) booklet describes the terms and conditions of coverage of your Blue Shield Life dental plan. It is your right to view the COI prior to enrollment in the dental plan.

To obtain a copy of the COI or if you have questions about the Benefits of the Plan, please contact the Dental Customer Service Department at (888) 679-8928. The hearing impaired may contact Customer Service by calling the TTY number at (977) 218-7138.

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 Summary of Benefits, summarizing key elements of the Blue Shield Life group 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 Certificate of Insurance 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.

This dental INO Plan (in-network only plan, also known as exclusive provider organization plan) is specifically designed for you to use Participating Dentists (in network). If you choose to use Non-Participating Dentists (non-network dentists), those services will not be covered and you will have to pay all charges yourself. You can control your out-of-pocket costs by carefully choosing Participating Dentists to provide your Covered Services. A Dental Plan Administrator (DPA) has a network of Participating Dentists. To select a Participating Dentist, see the section below entitled "Before Obtaining Dental Services".

IMPORTANT

All Covered Services, except for Emergency Services, must be provided by Participating Dentists. No Benefits are provided when you receive services from a Non-Participating Dentist, except for Medically Necessary Covered Services received for emergency care. If a Participating Dentist refers you to a Non-Participating Dentist, you are responsible for the total amount billed by the Non-Participating Dentist (billed charges).

Choice of 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.

Participating Dentists submit claims for payment after their services have been rendered. These payments go directly to the Participating Provider. 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 Insureds in an appropriate manner consistent with the Policy. If you want to know more about this payment system, contact Customer Service at the number provided on the back page of this booklet.

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

Continuity of Care by a Terminated Provider

Insureds 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.

Liability of Subscriber or Enrollee for Payment

Services received from Non-Participating Dentists are not covered, except for Emergency 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 Life'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 Dentist obtains precertification of Benefits.

Facilities

Directories of Participating Dentists are available on our website http://www.blueshieldca.com or by calling 1-888-702-4171.

Continuity of Care by a Terminated Dentist

Insureds 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 an Insured is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Insured 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 the Member Service Department at (800) 585-8111.

Principal Benefits and Coverages

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

Limitations and Exclusions

General Exclusions

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

1. charges for services in connection with any treatment to the gums for tumors, cysts, and neoplasms;
2. charges for Implants or the removal of Implants (surgically or otherwise) and any appliances and/or crown attached to Implants unless your plan provides special Implant Benefits;
3. services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if a contracted Dental Plan Administrator or Blue Shield Life provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by a contracted Dental Plan Administrator or Blue Shield Life for the treatment of such injury or disease;
4. charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint;
5. congenital mouth malformations or skeletal imbalances, including treatment required as the result of orthognathic surgery, Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
6. all prescription and non-prescription drugs;
7. charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
8. services, procedures, or supplies that are not Medically Necessary for the care of the Insured's dental condition or which are Experimental or Investigational in Nature;
9. services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;
10. procedures which are principally cosmetic in nature, such as bleaching, veneers, and personalization or characterization of dentures;
11. the replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) within five (5) years of its installation;
12. myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures;
13. orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;
14. charges for services in connection with orthodontia, except as listed under "Orthodontic Services";
15. alloplastic bone grafting materials;
16. bone grafting done for socket preservation after tooth extraction or in preparation for Implants (unless your plan provides special implant Benefits. Please see the Summary of Benefits to determine if you have implant Benefits.);

17. charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
18. extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
19. dental services performed in a hospital or any related hospital fee;
20. 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;
21. for which the Insured is not legally obligated to pay, or for services for which no charge is made;
22. treatment as a result of accidental injury including setting of fractures or 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);
23. treatment for which payment is made by any governmental agency, including any foreign government;
24. charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
25. charges for onlays or crowns installed as multiple abutments;
26. any inlay restorations;
27. charges for dental appointments which are not kept, except as specified under the Summary of Benefits;
28. charges for services incident to any intentionally self-inflicted injury;
29. general anesthesia including intravenous and inhalation sedation, except when of Medical Necessity.

    General anesthesia is considered Medically Necessary when its use is:

    a. in accordance with covered oral surgery procedures and generally accepted professional standards; and
    b. not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; or
    c. due to the existence of a specific medical condition;

    Patient apprehension or patient anxiety will not constitute Medical Necessity.

    A contracted Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Medical Necessity;
30. removal of 3rd molar (wisdom) teeth, except to treat a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not covered;
31. 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;
32. charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
33. any service, procedure, or supply which is received or started prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have started is defined as follows:
    a. for full dentures or partial dentures: on the date the final impression is taken;
    b. for fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
    c. for root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex;
    d. for periodontal surgery: on the date the surgery is actually performed;
    e. for all other services: on the date the service is performed;
34. 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;
35. any and all implant services that have not been prior authorized and approved by a contracted Dental Plan Administrator if your plan provides special implant Benefits;
36. non-Emergency Services provided by a Non-Participating Dentist.

Orthodontic Limitations and Exclusions

1. treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
2. surgical Orthodontics (including extraction of teeth) incidental to orthodontic treatment;
3. treatment for myofunctional therapy;
4. changes in treatment necessitated by an accident;
5. treatment for TMJ (temporomandibular joint) disorder or dysfunction;
6. ceramic braces which are considered to be cosmetic;
7. replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
8. treatment exceeding twenty-four (24) months except for treatment prior approved by Blue Shield Life as Medically Necessary;

9. in the event of a Insured's loss of coverage for any reason, if at the time of loss of coverage the Insured is still receiving Orthodontic treatment during the 24 month treatment period, the Insured and not the contracted Dental Plan Administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's billed charges, prorated for the number of months remaining;

10. if the Insured is reinstated after cancellation, there are no Orthodontic Benefits for treatment begun prior to his or her reinstatement effective date;

11. if the Insured elects to use invisalign, lingual or invisible braces, sapphire or clear braces, additional costs beyond what Blue Shield Life will pay for "standard" Orthodontic system of brackets and wires will be paid by the Insured.

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

Medical Necessity Exclusion

All services must be of Medical Necessity. The fact that a Dentist or other provider may prescribe, order, recommend, or approve a service does not, in itself, make it of Medical Necessity.

Alternate Benefit Provision

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

General Limitations

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

1. one (1) in a six (6) month period:
   A. periodic oral exam;
   B. child fluoride treatment for eligible Members through the end of the month in which the Member turns nineteen (19);
   C. bitewing x-rays (two (2) sets of single films or one (1) set of two films); and
   D. recementations if the crown or inlay was provided by other than the original dentist; not eligible if the dentist is doing the recementation of a service he/she provided within twelve (12) months;
   E. periodontal prohylaxis (recall or maintenance) not more than a combined total of one (1) periodontal and/or regular prophylaxis per each period of six (6) consecutive months.

2. one (1) in a twelve (12) month period:
   A. denture (complete or partial) reline;
   B. oral cancer screening;
      - adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures; and
   C. bitewing x-rays (three films or four films);

3. one (1) in twenty-four (24) months:
   A. Diagnostic casts:
      - working models taken in conjunction with a prosthetic or other appliance are not considered to be diagnostic casts;
   B. sealants through the end of the month in which the Member turns nineteen (19) on permanent first and second molars.
   C. occlusal guards; and
   D. gingival flap surgery per quad

4. one (1) in thirty-six (36) months:
   A. mucogingival surgery per area;
   B. osseous surgery per quad;
   C. gingivectomy per quad;
   D. gingivectomy per tooth;
   E. bone replacement grafts for periodontal purposes;
   F. guided tissue regeneration for periodontal purposes;
   G. full mouth series and panoramic x-rays includes ten (10) to fourteen (14) periapical x-rays and supplementary bitewing films:
      - X-rays required to diagnose a specific condition are not subject to limitations stated above;
   H. full mouth debridement;
   I. intraoral x-rays – complete series including bitewings.
   J. panoramic film.

5. one (1) in a five (5) year period:
   A. single crowns and onlays;
   B. single post and core buildups;
   C. crown buildup including pins;
   D. prefabricated post and core;
   E. cast post and core in addition to crown;
   F. complete dentures;
   G. partial dentures;
   H. fixed partial denture (bridge) pontics;
   I. fixed partial denture (bridge) abutments;
   J. abutment post and core buildups.

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

7. space maintainers – only eligible for Insureds through age eleven when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop;

8. Caries Risk Management — CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). For each risk level the following is covered:
   A. "high risk" will be allowed up to four (4) fluoride varnish treatments during the Calendar Year along with their biannual cleanings;

B. “medium risk” will be allowed up to three (3) fluoride varnish treatments in addition to their biannual cleanings; and
C. “low risk” will be allowed up to two (2) fluoride varnish treatments in addition to biannual cleanings.

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).

9. oral surgery services are limited to removal of teeth, bony protuberances and frenectomy;

10. 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 (3) teeth missing in one quadrant or in the anterior region. The ABP does not commit the Insured to the less costly treatment. However, if the Insured and the Dentist choose the more expensive treatment, the Insured is responsible for the additional charges beyond those allowed for the ABP;

11. general or IV sedation is covered for:
    A. three (3) or more surgical extractions;
    B. any number of Medically Necessary impactions;
    C. full mouth or arch alveoloplasty;
    D. surgical root recovery from sinus;
    E. medical problem contraindicates the use of local anesthesia;
    F. children under the age of seven (7) years old.
        - General or IV sedation is not a covered benefit for dental phobic reasons. Deep sedation/general anesthesia is covered for up to one hour per visit;

12. restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth;

13. root canal treatment – one (1) per tooth per lifetime;

14. root canal treatment – one (1) per tooth per lifetime;

15. for mucogingival surgeries, one site is equal to two (2) consecutive teeth or bounded spaces;

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

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;

18. you must be twenty-one (21) years old 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 member will be given an alternate Benefit of a partial denture. If the Member elects a different procedure, payment will be based on the partial denture Benefit.

Limitation on Liability of Subscribers

In accordance with Blue Shield Life's established policies, and by statute, every Policy 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 Policy. When services are provided by a Participating Dentist, the Subscriber is responsible for any applicable Deductible, Coinsurance amounts, and charges in excess of Benefit maximums.

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

Prepayment Fee

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

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

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

Plan Changes

The Benefits of this Plan, including but not limited to Covered Services, Deductible, and Coinsurance amount, are subject to change at any time. Blue Shield 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.

Blue Shield Life Online

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

Choice of Providers

Under this Blue Shield Life INO Dental Plan, you have a choice of any Participating Dentist including Participating Dentists outside of California.

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 Life's Internet site located at http://www.blueshieldca.com.

Grievance Process

Blue Shield Life has established a grievance procedure for receiving, resolving, and tracking Insureds' 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 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 http://www.insurance.ca.gov/contact-us/0200-file-complaint.

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.

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 Insureds when the Subscriber's Employer (Policyholder) 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 Insured will be entitled to elect to continue group coverage under this Plan if the Insured would otherwise lose coverage because of a Qualifying Event (defined in the COI) that occurs while the policy 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 Insured if the Qualifying Event had not occurred (including any changes in such coverage).

Note: An Insured will not be entitled to benefits under Cal-COBRA if at the time of the Qualifying Event such Insured 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, an Insured is entitled to Benefits if at the time of the qualifying event such Insured 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.

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 Insured 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 reim-

bursement for dental expenses, such Insured 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 Insured is also entitled to Benefits under any of the conditions as outlined under the "Limitations for Duplicate Coverage" provision, Benefits received under any such condition will not be coordinated with the Benefits of the Plan.

The following rules determine the order of benefit payments:

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

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

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

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

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

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

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

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

If the Plan is the primary carrier with respect to a covered Insured, 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 Life 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 Insured (1) assigns to a contracted Dental Plan Administrator or Blue Shield Life 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 Life actually pays and the amount that a contracted Dental Plan Administrator or Blue Shield Life would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with a contracted Dental Plan Administrator or Blue Shield Life in obtaining payment of Benefits from the other plan, and (3) allows Blue Shield Life 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 Life 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 Life shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by Blue Shield Life in excess of the maximum amount of payment necessary to satisfy these provisions, Blue Shield Life 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 Life may release to or obtain from any organization or person any information which Blue Shield Life 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 Life with such information as may be necessary to implement these provisions.

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 the Customer Service Department at the number listed in the Customer Service section of this booklet, or by accessing Blue Shield Life's internet site located at http://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:

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 (Covered Services) – those services which an Insured is entitled to receive pursuant to the Group Dental Service Policy.

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

Covered Services (Benefits) – those services which an Insured is entitled to receive pursuant to the terms of the Group 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 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 licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

Dependent –

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

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

   or,
3. a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber who is less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by Blue Shield 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.

4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:

   a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

   b. the Subscriber, spouse, or Domestic Partner submits to Blue Shield 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 one another's lives in an intimate and committed relationship of mutual caring;

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

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

5) The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this Plan. If permitted by your Employer, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code).

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

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

1. placing the patient's health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part.

Employee – an individual who meets the eligibility requirements set forth in the Group Dental Policy between Blue Shield Life and your Employer.

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

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

Family – the Subscriber and all enrolled Dependents.

Group Dental Policy (Policy) – the policy issued by the Plan to the Policyholder 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).

Insured – 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'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. Services received from Non-Participating Dentists are not covered, except for Emergency Services.

Open Enrollment Period – that period of time set forth in the policy during which eligible employees and their dependents may transfer from another health benefit plan sponsored by the Employer to this Plan.

Orthodontic (Orthodontics) – 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.

Plan – the Blue Shield Life INO Dental Plan and/or Blue Shield Life.

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

Subscriber – an Employee as defined, who has been enrolled and accepted by Blue Shield Life as a member of the group policy and has maintained his or her Blue Shield Life coverage under the terms of this group policy.