Disclosure

Dental HMO Plan Disclosure Form

Blue Shield Disclosure Form:

Dental HMO Plan

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

The Evidence of Coverage (EOC) booklet describes the terms and conditions of coverage of your Blue Shield dental Plan. It is your right to view the EOC prior to enrollment in the dental Plan.

To obtain a copy of the EOC or if you have questions about the Benefits of the Plan, please contact the Dental Customer Service Department at (888) 702-4171. The hearing impaired may contact Customer Service by calling the TTY number at (800) 241-1823.

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 of California 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 Member Services at (888) 702-4171 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Disclosure document.

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Blue Shield of California's (Blue Shield) dental Plans are administered by a Dental Plan Administrator (DPA). PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR DENTAL CARE MAY BE OBTAINED.

Choice of Dental Providers

SELECTING A DENTAL PROVIDER

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

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

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

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

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

Liability of Subscriber or Enrollee for Payment

You are responsible for assuring that the Dentist you choose is a Dental Provider. A Dental Provider's status may change. It is your obligation to verify whether the Dentist you choose is currently a Dental Provider; in case there have been changes to the list of Dental Providers. You are also responsible for following the Precertification of Benefits Program.

Facilities

Directories of Participating Dentists are available on our website http://www.blueshieldca.com or by calling (800) 286-7401.

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 Dental Plan Administrator's Participating Dentist Network. Contact Member Services 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 Dental Provider in the same geographic area.

Utilization Review

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

Blue Shield has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code.

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

Principal Benefits and Coverages

The Benefits available to you under the Plan are listed in the Summary of Benefits which is inserted as part of this booklet. The Copayments for these services, if applicable, are also listed in the Summary of Benefits.

General Exclusions and Limitations

General Exclusions

Unless otherwise specifically mentioned elsewhere in the Contract this Plan does not provide Benefits with respect to:

1. dental services not appearing on the Summary of Benefits;
2. services of Dentists or other practitioners of healing arts not associated with the Dental Plan, except upon referral arranged by a Dental Provider and authorized by the Plan or when required in a covered emergency;
3. any service, procedure, or supply which is received or expenses incurred prior to the patient's effective date of coverage;any service, procedure, or supply which is received or expense incurred 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 had expenses incurred 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.

4. dental services performed in a hospital or any related hospital fee;
5. any procedure not performed in a dental office setting; except for general anesthesia when Medically Necessary.
6. 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;
7. services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;
8. all prescription and non-prescription drugs;
9. congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery, including Orthodontic treatment, and oral and maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging;
10. any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by the Dental Plan Administrator and its dental consultants;
11. reimbursement to the Member or another dental office for the cost of services secured from Dentists, other than the Dental Center or other Dental Provider, except:
    a. when such reimbursement is expressly authorized by the Plan; or
    b. as cited under the Emergency Services and Emergency Claims provisions;
12. charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
13. 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;
14. treatment for which payment is made by any governmental agency, including any foreign government;
15. 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;
16. bone grafting done for socket preservation after tooth extraction or in preparation for Implants;
17. general anesthesia; including intravenous and inhalation sedation, except when of Medical Necessity.
18. General anesthesia is considered Medically Necessary when its use is:
    a. in accordance with generally accepted professional standards;
    b. not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; and
    c. due to the existence of a specific medical condition.
19. Written documentation of the medical condition necessitating use of general anesthesia or intravenous or sedation must be provided by a physician (M.D.) to the Dental Provider and approved by a Dental Plan Administrator.
20. Patient apprehension or patient anxiety will not constitute Medical Necessity.
21. Mental disability is an acceptable medical condition to justify use of general anesthesia.
22. The Plan reserves the right to review the use of general anesthesia to determine Medical Necessity;
23. precious metals (if used, will be charged to the patient at the Dentist's cost);
24. removal of 3rd molar (wisdom teeth) other than for Medical Necessity. Medical Necessity pertaining to the removal of 3rd molar (wisdom teeth) is defined as a pathological condition which includes horizontal, mesial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not Medical Necessity;

25. referral of a Dependent child age six (6) and over to a pedodontist (specialist in children's dentistry), unless the child is mentally disabled and will not allow the general Dentist to treat after two attempts. All such exceptions must be approved by a Dental Plan Administrator;
26. treatment as a result of Accidental Injury, including setting of fractures or dislocation;
27. charges for second opinions, unless previously authorized by the Dental Plan Administrator;
28. 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;
29. services provided to Members by out-of-network Dentists unless Preauthorized by the Company, except when immediate dental treatment is required as a result of a dental emergency;
30. 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;
31. replacement of lost, missing, stolen or damaged or prosthetic device;
32. services arising from voluntary self - inflicted injury or illness, whether the patient is sane or insane;
33. house calls for dental services;
34. training and/or appliances to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
35. 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;
36. temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
37. replacement of existing crowns, bridges or dentures that are less than five (5) years old;
38. charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
39. duplicate dentures, prosthetic devices or any other duplicate appliance.
40. any and all Implant services that have not been prior authorized and approved by a Dental Plan Administrator if your Plan provides special implant benefits. Implants that are used as an abutment, double abutment, or bone anchor to support or hold a fixed bridge, orthodontic appliance, removable prosthesis, or oral-maxillofacial prosthesis are not covered.

Orthodontic Exclusions

1. treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
2. surgical Orthodontics incidental to Orthodontic treatment;
3. treatment for myofunctional therapy;
4. changes in treatment necessitated by an accident;
5. re-treatment of Orthodontic cases when a Dental Plan Administrator concurs with the professional judgment of the attending Dentist that there is a poor prognosis;
6. treatment for TMJ (Temporomandibular joint) disorder or dysfunction;
7. ceramic braces which are considered to be cosmetic;
8. x-rays for Orthodontic purposes (to include full mouth screen and cephalometrics);
9. replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
10. treatment which is received in more than one course of treatment, or which is not received in consecutive months, or treatment exceeding twenty-four (24) consecutive months;
11. in the event of a Member's loss of coverage for any reason, if at the time of loss of coverage the Member is still receiving Orthodontic treatment during the twenty four (24) month treatment period, the Member and not the 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.
13. if the Member elects to use invisalign®, lingual or invisible braces, sapphire or clear braces, additional costs beyond what BSC will pay for “standard” Orthodontic system of brackets and wires will be paid by 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.

Medical Necessity Exclusion

All services must be of Medical Necessity. The fact that a Dentist or other Participating Dentist may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Medical Necessity even though it is not specifically listed as an exclusion or limitation, Blue Shield may limit or exclude Benefits for services which are not of Medical Necessity.

Limitations

The following services, if listed on the Summary 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. fluoride treatment;
    C. bitewing x-rays (maximum four (4) per year:
    D. tissue conditioning;
    E. 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;
    F. Periodontic maintenance
2. one (1) in twelve (12) months:
    A. denture (complete or partial) reline.
    B. oral cancer screening;
    C. topical fluoride varnish (coverage limited to three (3) applications, when used as a therapeutic application in patients with a moderate-to-high carries risk).
3. one (1) in twenty-four (24) months:
    A. full mouth debridement;
    B. gingival flap surgery per quad;
    C. diagnostic casts;
    D. sealants;
    E. occlusal guards
4. one (1) in thirty-six (36) months:
    A. mucogingival surgery per area;
    B. osseous surgery per quad;
    C. gingival flap surgery per quad;
    D. gingivectomy per quad;
    E. gingivectomy per tooth;
    F. bone replacement grafts for periodontal purposes per site;
    G. guided tissue regeneration for periodontal purposes per site;
    H. full mouth series and panoramic x-rays;
    I. intraoral x-rays – complete series including bitewings
5. one (1) in a five (5) year period:
    A. single crowns and onlays;
    B. single post and core buildups;
    C. crown buildup including pins;
    D. prefabricated post and core;
    E. cast post and core in addition to crown;
    F. complete dentures;
    G. partial dentures;
    H. fixed partial denture (bridge) pontics;
    I. fixed partial denture (bridge) abutments;
    J. abutment post and core buildups;
    K. diagnostic cast
6. two (2) in a consecutive twelve (12) month period:
    A. routine prophylaxis
7. referral to a specialty care Dentist is limited to Orthodontics, Oral Surgery, Periodontics, Prosthodontics, Endodontics and Pedodontics.
8. coverage for referral to a pediatric specialty care Dentist is covered up to the age of six (6) and is contingent on Medical Necessity. However, exceptions for physical or mental disabilities or medically compromised children six (6) years and over, when confirmed by a physician, may be considered on an individual basis with prior approval.
9. space maintainers – only eligible for Members 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.
10. payment for Orthodontic treatment is made in installments. If for any reason Orthodontic services are terminated or coverage is terminated before completion of the approved Orthodontic treatment, the responsibility of the Dental Plan Administrator will cease with payment through the month of termination.
11. sealants – one (1) per tooth per two (2)-year period through the end of the month in which the Member turns nineteen (19) on permanent first and second molars.
12. child fluoride (including fluoride varnish) – one (1) per six (6) month period through the end of the month in which the Member turns nineteen (19).
13. in the case of a dental emergency involving pain or a condition requiring immediate treatment occurring more than fifty (50) miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an out-of-network Dentist up to the difference between the out-of-network Dentist's charge and the Member Copayment up to a maximum of $50 for each emergency visit.
14. Oral Surgery services are limited to removal of teeth, bony protuberances and frenectomy.
15. 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 Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.
16. general or IV Sedation is covered for
    A. three (3) or more surgical extractions;
    B. any number of one (1) Medically Necessary impactions;
    C. full mouth or arch alveoloplasty;
    D. surgical root recovery from sinus;

E. medical problem contraindicates local anesthesia;

17. General or IV sedation is not a covered Benefit for dental phobic reasons.
18. scaling and root planing – covered once for each of the four (4) quadrants of the mouth in a twenty-four (24) month period. Scaling and root planing is limited to two (2) quadrants of the mouth per visit.
19. restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or accidentally fractured teeth.
20. root canal treatment – one (1) per tooth per lifetime.
21. root canal retreatment – one (1) per tooth per lifetime.
22. pulpal therapy – through age five (5) on primary anterior teeth and through age eleven (11) on primary posterior teeth.
23. for mucogingival surgeries, one (1) site is equal to two (2) consecutive teeth or bounded spaces;
24. 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;
25. you must be age twenty-one (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 and/or non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If there are more than three teeth missing and/or more than three non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, 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.

Prepayment Fee

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

All Dues required for coverage for you and your Dependents will be handled through your Employer and must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this group Contract up to the date immediately before the next transmittal date, but not after.

The Dues 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 Dues at least 60 days prior to the change. Your Employer will then notify you immediately. Note: This paragraph does not apply to a Member who is enrolled under a Contract where monthly Dues automatically increase, without notice, the first day of the month following an age change that moves the Member into the next higher age category.

Other Charges

Blue Shield of California's dental HMO plans have no deductibles and no Calendar Year maximums.

Copayments

Copayment amounts for Covered Services under your dental HMO are shown in the Summary of Benefits which is provided as part of this booklet.

Reimbursement Provisions

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

A 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 Dental Plan Administrator within 1 year after the month of service. A Dental Plan Administrator will notify you of its determination within 30 days after the receipt of the claim.

Services not provided, prescribed or authorized by your Dental Provider are not covered, unless authorized by the Plan or when required in an emergency, as stated in the EOC.

Renewal Provisions

The Group Dental Service Contract is issued for a one year period.

Plan Changes

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

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

Individual Continuation of Benefits

Cal-COBRA Coverage

State law provides that Subscribers who enroll in a group plan and later lose eligibility may be entitled to continuation of group coverage. Please refer to the EOC for information regarding your eligibility for Cal-COBRA.

COBRA Coverage

If your employment with your current Employer ends, you and your covered Family Members may qualify for continued group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The section in the EOC entitled Continuation of Group Coverage has information on COBRA.

Termination of Benefits

Blue Shield may terminate coverage if:

(1) There is a violation of a material contract provision relating to Employer contribution or group participation rates by the Contractholder/Employer;

(2) Blue Shield terminates a particular product or all products offered in the large group market as permitted or required by law. If Blue Shield discontinues offering a particular product in a market, Blue Shield will send you written notice at least 90 days before the product terminates. If Blue Shield discontinues offering all products to groups in the large group market, Blue Shield will send you written notice at least 180 days before the Contract terminates;

(3) A Member or Employer ceases to be a member of a guaranteed association.

Group Termination

Blue Shield may cancel the Contract for non- payment of Dues.

If the Employer fails to pay the required Dues when due, coverage will end 30 days after the date for which Dues are due. Your Employer will be liable for all Dues accrued while this Plan continues in force including those accrued during the 30 day grace period.

If Blue Shield's Group Dental Service Contract is terminated, you will no longer receive Benefits – including COBRA or Cal-COBRA coverage. Exceptions due to a disability are specifically outlined in the Extension of Benefits provision in the EOC.

Individual Termination

In addition to termination of your Employer's Group Dental Service Contract with Blue Shield, you will no longer be eligible for coverage under the Plan if:

1. You no longer meet the eligibility requirements in your Employer's Group Dental Service Contract;
2. You engage in fraud or deception in the use of dental Plan Benefits.

Please refer to the EOC or your Employer's Group Dental Service Contract for additional information.

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.

Grievance Process

Blue Shield of California has established a grievance procedure for receiving, resolving, and tracking Members' grievances. For more information on this process, see the Grievance Process section in the EOC.

External Independent Medical Review

State law requires Blue Shield to disclose to Members the availability of an external independent review process when your grievance involves a claim or services for which coverage was denied by Blue Shield or by a Dental Provider in whole or in part on the grounds that the service is not a Medical Necessity or is Experimental or Investigational in Nature. You may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. For further information about whether you qualify or for more information about how this review process works, see the External Independent Medical Review section in the EOC.

California Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at **1-800-424-6521** 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website

(www.dmhc.ca.gov) has complaint forms, IMR application forms, and instructions online.

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

Confidentiality of Personal and Health Information

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Blue Shield 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 DENTAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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

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

Correspondence Address:

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

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

Coordination of Benefits

For more detailed information about Blue Shield's Coordination of Benefits procedure, please refer to the Evidence of Coverage (EOC), or call customer service at 1-888-702-4171.

Definitions

Terms used throughout this Disclosure Form are defined as follows:

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

Allowable Amount - the amount a Participating Dentist agrees to accept as payment from a Dental Plan Administrator or the billed amount for Non-Participating Dentists.

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.

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

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

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

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

Copayment - the specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

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

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

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

Dental Plan Administrator (DPA) - Blue Shield of California has contracted with a Dental Plan Administrator (DPA). A DPA is a dental care service Plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of dental services through a network of Participating Dentists and Dental Centers.

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

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. not covered for Benefits as a Subscriber;

   and

   b. not legally separated from the Subscriber;

   or,

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

   or,

3. a child of, adopted by, or in legal guardianship of the Subscriber, spouse or Domestic Partner, who is unmarried and is not in a domestic partnership. This category includes any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber and who is less than 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 the Plan as a Dependent and has maintained membership in accordance with the contract.

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

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

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

   c. thereafter, certification of continuing disability and dependency from a physician is submitted to Blue Shield on the following schedule:

      (1) within twenty-four (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.

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

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

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

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

Employer (Contractholder) - any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least two (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.

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

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

Family - the Subscriber and all enrolled Dependents.

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

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).

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 generally accepted standards of dental practice referenced in the Dental Plan Administrator's dental policy;
    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 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 Member's illness, injury, or dental condition.

Member - either a Subscriber or Dependent.

Open Enrollment Period - that period of time set forth in the Contract during which eligible individuals and their Dependents may enroll in the Plan.

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

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

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

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

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

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

Plan - the Blue Shield Dental Plan.

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

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

Service Area - that geographic area served by the Plan.

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

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

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

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。