Disclosure

Specialty Duo Dental Plan

For Medicare Supplement Members

Blue Shield Life Disclosure Form: Specialty Duo Dental Plan For Medicare Supplement Members

This Disclosure Form is only a summary of your dental plan. The Dental Service Policy should be consulted to determine the terms and conditions governing your coverage. 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 711.

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

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

IMPORTANT

If you opt to receive dental services that are not covered services under this Plan, a Participating Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call 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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PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR DENTAL CARE MAY BE OBTAINED.

The Specialty Duo (Dental + Vision) Plan package for Medicare Supplement members consists of a dental plan and a vision plan which is offered at a package rate. This Policy describes the Benefits of the Specialty Duo Dental Plan for Medicare Supplement members, the dental plan in the Specialty Duo (Dental + Vision) package for Medicare Supplement members.

Blue Shield Life's dental plans are administered by a Dental Plan Administrator (DPA) which is an entity that contracts with Blue Shield Life to underwrite and administer the delivery of dental services through a network of Participating Dentists.

Choice of Dentists

The Specialty Duo Dental Plan Smile PPO for Medicare Supplement members is specifically designed for you to use Participating Dentists. Participating Dentists agree to accept a Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Copayment/Coinsurance, as payment in full for Covered Services. This is not true of Non-Participating Dentists.

Participating Dentists submit claims for payment after Dental Care Services have been rendered. Payments for these claims go directly to the Participating Dentist. You or your Non-Participating Dentists submit claims for reimbursement after services have been rendered. If you receive Dental Care Services from Non-Participating Dentists, you have the option of having payments sent directly to the Non-Participating Dentist or sent directly to you. A Dental Plan Administrator will notify you of its determination within 60 days after receipt of the claim.

Participating Dentists do not receive financial incentives or bonuses from Blue Shield Life.

You may access a Directory of Participating Dentists through Blue Shield Life's Internet site located at http://www.blueshieldca.com. The names of Participating Dentists in your area may also be obtained by contacting a Dental Plan Administrator at 1-888-679-8928.

Liability of Subscriber or Enrollee for Payment

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

Facilities

Directories of Participating Dentists are available on our website Blueshieldca.com or by calling (888) 702-4171.

Service Area

The Service Area of this Plan is identified in the Dental Provider Directory. You and your eligible Dependents must live or work in the Service Area identified in those documents to enroll in this Plan and to maintain eligibility in this Plan.

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

Financial Responsibility for Continuity of Care Services

If a Insured is entitled to receive Services from a terminated dentist under the preceding Continuity of Care provision, the responsibility of the Insured to that dentist 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 Benefits Summary which is provided as part of this booklet. Blue Shield Life payments for these Services, if applicable, are also listed in the Benefit Summary.

Principal Exclusions and Limitations on Benefits

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;

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 syndrome (TMJ) 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. Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;

6. 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);

7. All prescription and non-prescription drugs;

8. Services, procedures, or supplies which are not reasonably necessary for the care of the Insured'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;

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, including, but not limited to, bleaching, veneer facings, crowns, personalization or characterization of crowns, bridges and/or dentures;

11. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been either lost or stolen within five (5) years of its installation;

12. Myofunctional therapy; biofeedback procedures;athletic mouth-guards; precision or semiprecision attachments; denture duplication; 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;

15. Alloplastic bone grafting materials;

16.Bone grafting done for socket preservation after tooth extraction or in preparation for implants;

17. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;

18. Any procedure not performed in a dental office setting;

19. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);

20. Dental services performed in a hospital or any related hospital fee;

21. 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;

22. Services for which the Insured is not legally obligated to pay, or for Services for which no charge is made;

23. Treatment as a result of accidental injury including setting of fractures or dislocation;

24. Treatment for which payment is made by any governmental agency, including any foreign government;

25. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment; 26. Charges for onlays or crowns installed as multiple abutments;

27. Charges for dental appointments which are not kept;

28. Charges for any inlay restoration;

29. Charges for services incident to any intentionally self-inflicted injury;

30. General anesthesia including intravenous and inhalation sedation, except when of dental necessity.

General anesthesia is considered Dentally Necessary when its use is:

a) In accordance with generally accepted professional standards; and

b) Not furnished primarily for the onvenience of the patient, the attending Dentist, or other provider;

c) Due to the existence of a specific medial condition. Patient apprehension or patient anxiety will not constitute Dental Necessity. A contracted Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Dental Necessity;

31. Removal of 3rd molar (wisdom) teeth other than for Dental Necessity. Dental Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not dental necessity.

32. 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;

33. For 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; and

34. 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

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.

Dental Necessity Exclusion
All services must be of Dental Necessity. The fact that a Dentist or other plan provider

may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Dental Necessity.

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

General Limitations

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

1. One (1) in a four (4) month period
   a) Routine prophylaxis

2. One (1) in a six (6) month period:
   a) Periodic oral exam;
   b) Bitewing x-rays, maximum for (4) per occurrence; and
   c) Recementations if the crown 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 months;

3. One (1) in twelve (12) month period:
   a) Denture (complete and partial) relines; and
   b) Oral cancer screening;

4. One in twenty-four (24) months:
   a) Full mouth debridement;
   b) Scaling and root planing per area (limited to two (2) quadrants per visit);
   c) Occlusal guards;

5. One (1) in a thirty-six month period:
   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;
   g) Guided tissue regeneration for periodontal purposes

6. One (1) in a five (5) year period:

   a) Full mouth series and panoramic x-rays;
   b) Single crowns and onlays;
   c) Single post and core buildups;
   d) Crown buildup including pins;
   e) Prefabricated post and core;
   f) Cast post and core in addition to crown;
   g) Complete dentures;
   h) Partial dentures;
   i) Fixed partial denture (bridge) pontics;
   j) Fixed partial denture (bridge) abutments;
   k) Abutment post and core buildups;
   l) Diagnostic casts;

7. Oral surgery services are limited to removal of teeth, bony protuberances and frenectomy;

8. The 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 of a partial denture will be applied when there are bilaterally missing teeth or more than 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;

9. General, IV or Inhalation Sedation is covered for:
   a) 3 or more surgical extractions;
   b) Dentally Necessary impactions;

c) Full mouth or arch alveoloplasty;
d) Surgical root recovery from sinus;
e) Medical problem contraindicates local anesthesia;

General or IV Sedation is not a covered benefit for dental phobic reasons;

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

11. Root canal treatment – one per tooth per lifetime;

12. Root canal retreatment – one per tooth per lifetime.

Premiums

Monthly Premiums are as stated in the Dental Policy Appendix. Blue Shield Life offers a variety of options and methods by which you may pay your Premiums. Please call Customer Service at 1-800-431-2809 to discuss these options or visit the Blue Shield Life internet site at http://www.blueshieldca.com.

Payments by mail are to be sent to:

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

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

Other Charges

Deductible

For dental Plans with a Calendar Year deductible, the deductible applies to all Covered Services and supplies furnished by Participating and Non- Participating Dentists, except as specified in the Benefit Summary which is attached to and made a part of this Disclosure Form. It is the amount which you must pay out of pocket for charges that would otherwise be payable for Dental Care Services and supplies. Charges in excess of the Allowable Amount do not apply toward the deductible. This per Insured deductible applies separately to each covered Insured each Calendar Year, except that no more than the Family deductible amount is required of a Family in a Calendar Year.

The Calendar Year per Insured and Family deductible amounts, if applicable, are listed in the benefit summary.

Coinsurance and Benefit Maximums

Responsibilities

After any applicable deductible has been satisfied, payments will be provided based on the Allowable Amount determined by the Dental Plan Administrator, to Participating and Non-Participating Dentists for the Benefits of this Plan, subject to the Coinsurance.

The maximum per Insured, per Calendar Year amount payable by Blue Shield Life for Covered Services and supplies provided by any combination of Participating Dentists and Non-Participating Dentists is listed in the Benefit Summary.

**NOTE: if your Plan provides Benefits for Orthodontia, a separate Calendar Year Benefit maximum applies to Orthodontic Services. See the Benefit Summary.

Plan Changes

The Benefits and rates of the Plan are subject to change following at least 60 days' written notice by Blue Shield Life. Benefits for Services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

Duration of the Policy

This Policy shall be renewed upon receipt of prepaid Premiums. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in Premiums or Benefits, including but not limited to Covered Services, Deductible, Copayment, Coinsurance, and Calendar Year Maximum Payment, are effective after 60 days notice to the Subscriber's address of record with Blue Shield Life.

Renewal of the Policy

Blue Shield Life shall renew this Policy, except under the following conditions:

1. Non-payment of Premiums;

2. Fraud, misrepresentation, or omission;

3. Termination of plan type by Blue Shield Life;

4. Subscriber moves out of California or the Subscriber is no longer a Resident of California;

5. If a bona fide association arranged for the Subscriber's coverage under this Policy, when that Subscriber's membership in the association ceases.

Termination / Reinstatement of the Policy

This Policy may be terminated or cancelled as follows:

1. Termination by the Subscriber:
   A Subscriber desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.

2. Termination by Blue Shield Life through cancellation:

   Blue Shield Life may cancel this Policy immediately upon written notice for the following reasons:

   a. Fraud or deception in obtaining, or attempting to obtain, Benefits under this Policy;

   b. Knowingly permitting fraud or deception by another person in connection with this Policy, such as, without limitation, permitting someone to seek Benefits under this Policy, or improperly seeking payment from Blue Shield Life for Benefits provided;

   c. Abusive or disruptive behavior which: (1) threatens the life or well being of Blue Shield Life personnel and providers of Services; or (2) substantially impairs the ability of Blue Shield Life to arrange for Services to the Insured; or (3) substantially impairs the ability of providers of Service to furnish Services to the Insured or to other patients; or

   d. Failure or refusal to provide Blue Shield Life access to documents and other information necessary to determine eligibility or to administer Benefits under the Plan.

   Cancellation of the Policy under this section will terminate the Policy effective as of the date that written notice of

termination is mailed to the Subscriber. It is not retroactive to the original Effective date of the Policy.

3. Termination by Blue Shield Life if Subscriber moves out of California:

   Blue Shield Life may cancel this Policy upon thirty (30) days written notice if the Subscriber moves out of California.

   Within 30 days of the notice of cancellation under sections 2 or 3 above, Blue Shield Life shall refund the prepaid Premiums, if any, that Blue Shield Life determines will not have been earned as of the termination date. Blue Shield Life reserves the right to subtract from any such Premiums refund any amounts paid by Blue Shield Life for Benefits paid or payable by Blue Shield Life prior to the termination date.

4. Termination by Blue Shield Life due to withdrawal of the Policy from the Market:

   Blue Shield Life may terminate this Policy together with all like Policies to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll in any other individual dental Policy without regard to health status-related factors.

5. Cancellation of the Policy for Nonpayment of Premiums:

   Blue Shield Life may cancel this Policy for failure to pay the required Premiums, when due. If the Policy is being cancelled because you failed to pay the required Premiums when due, the Plan will provide written notice of non-payment and will terminate coverage no sooner than 30 days after the date of the written notice. You will be liable for all Premiums accrued while this Policy continues in force including those accrued during this 30 day grace period.

   Within five (5) business days of canceling Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

   a. That the Policy has been cancelled, and the reasons for cancellation; and

   b. The specific date and time when all coverage under this Policy ended.

6. Reinstatement of the Policy after Termination for Non-Payment:

   If the Policy is cancelled for nonpayment of Premiums the Plan will permit reinstatement of the Policy or coverage twice during any twelve-month period, without a change in Premiums and without consideration of your medical condition, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

   If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Plan may impose different Premiums and consider your medical condition.

Grace Period

After payment of the first Premiums, the Subscriber is entitled to a grace period of 31 days for the payment of any Premiums due. During this grace period, the Policy will remain in force. However, the Subscriber will be liable for payment of Premiums accruing

during the period the Policy continues in force.

Grievance Process

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

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

1-888-679-8928

Blue Shield Life
Dental Plan Administrator
425 Market Street, 15th Floor
San Francisco, CA 94105

A Dental Plan Administrator will acknowledge receipt of a written grievance within five (5) calendar days. Grievances are resolved within 30 days.

The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

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 711) to receive complaints regarding health insurance from either the Insured or his or her provider.
If you have a complaint against Blue Shield Life, 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. – 6 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.

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.

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 back of this booklet or 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 Number:
1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@blueshieldca.com

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.

Definitions

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

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

The Dental Plan Administrator Allowance is:

1. the amount the 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 the 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 Dental Provider and the 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 the Dental Plan Administrator determines is appropriate considering the particular circumstances and the Services rendered.

Benefits (Services) — those services which an Insured is entitled to receive pursuant to the 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 Dental Policy.

Dental Care Services — necessary treatment on or to the teeth or gums whether or not caused by Accidental Injury, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

Dental Necessity — services which are of Dental Necessity include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat dental disease or injury, and which, as determined by the Dental Plan Administrator, are:

1. Consistent with the symptoms or diagnosis; and
2. not furnished primarily for the convenience of the patient, the attending Dentist or other provider; and
3. furnished at the most appropriate level which can be provided safely and effectively to the patient.

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

Dentist — a licensed Doctor of Dental Surgery or Doctor of Dental Medicine.

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 Subscriber's, spouse's, or Domestic Partner's unmarried child or child who is not one of the partners in a domestic partnership (including 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:

   a. primarily Dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance; or

   b. Dependent upon the Subscriber, spouse, or Domestic Partner for medical support pursuant to a court order; and is

   c. less than 19 years of age; or

   d. less than 25 years of age if enrolled as a full-time student and if proof of student status is submitted to and received by Blue Shield Life (Note: This item d. does not apply to a child of a legal guardian unless a court has specifically ordered that the guardianship continue beyond the attainment of age 19). Full-time student means a Dependent must be enrolled in a college, university, vocational, or technical school for a minimum of 12 units as an undergraduate, or 6 units as a graduate student; and who has been enrolled and accepted by Blue Shield Life as a Dependent and has

maintained membership in accordance with the Policy.

4. If coverage for a Dependent child would be terminated because of the attainment of age 19 (or age 25, if Dependent has been a full-time student), 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. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring;

2. Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex Domestic Partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Emergency Services – Services provided for an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) tat 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.

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.

Dental Policy (Policy) — the Policy issued by the Plan that establishes the Services that Subscribers and Dependents are entitled to receive from the Plan.

Insured — either a Subscriber or an eligible Dependent.

Non-Participating Dentist — a Doctor of Dental Surgery or Doctor of Dental Medicine who has not signed a service contract with the Dental Plan Administrator to provide dental services to Insureds.

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

Plan — the Blue Shield Life Specialty Duo Dental Plan for Medicare Supplement members and/or Blue Shield Life.

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

Service Area — the geographic area served by the Plan.

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