Dental PPO Plan 1500
For
Medicare Supplement Subscribers

Evidence of Coverage and Health Service Agreement

Effective Date: January 1, 2012

Medicare Supplement

An Independent Member of the Blue Shield Association

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Blue Shield of California
Dental PPO Plan 1500
For
Medicare Supplement Subscribers

EVIDENCE OF COVERAGE AND HEALTH SERVICE AGREEMENT

This Evidence of Coverage and Health Service Agreement ("Agreement") is issued by California Physicians' Service d/b/a Blue Shield of California ("Blue Shield"), a not for profit health care service Plan, to the Subscriber whose identification cards are issued with this Agreement. In consideration of statements made in the application and timely payment of Dues, Blue Shield of California agrees to provide the benefits of this Agreement.

NOTICE TO NEW SUBSCRIBERS

Please read this Agreement carefully. If you have any questions, contact Blue Shield of California. You may surrender this Agreement by delivering or mailing it with the identification cards, within ten (10) days from the date it is received by you, to BLUE SHIELD OF CALIFORNIA, 50 BEALE STREET, SAN FRANCISCO, CALIFORNIA 94105. Immediately upon such delivery or mailing, the Agreement shall be deemed void from the beginning, and Dues paid will be refunded.

IMPORTANT!

No Person has the right to receive the benefits of this plan for Services or supplies furnished following termination of coverage. Benefits of this plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming benefits is actually covered by this Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply to Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Agreement.

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 1-800-248-2341 or your insurance broker. To fully understand your coverage, you should carefully review this Agreement.

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The Covered Services listed below are paid as indicated in the following Summary of Benefits. These Covered Services are subject to the sections of the Summary of Benefits entitled Calendar Year Deductible and Maximum Blue Shield of California Calendar Year Payment.

Summary of Benefits

Subscriber's Calendar Year Deductible (Dental Plan Deductible)	**Deductible Responsibility**	
	Participating Dentists	**Non-Participating Dentists**
The Deductible applies to all Covered Services incurred during a Calendar Year except for diagnostic and preventive services provided by Participating or Non-Participating Dentists.	$50	

Maximum Calendar Year Payment	**Maximum Blue Shield of California Calendar Year Payment**	
	Participating Dentists	Non-Participating Dentists
For all Covered Services The Plan pays up to the maximum payment amount as listed for Covered Services and supplies	$1,500[1]	$1,000[1]

Covered Services and Supplies	**Blue Shield of California Payment Percentage**	
	Participating Dentists	**Non-Participating Dentists**
Diagnostic and Preventive Services	100%	80%
Basic Services	80%	70%
Major Services[2]	50%	50%

[1] The maximum amount the Plan will pay for covered Services and supplies is $1,500 in a Calendar Year. Up to $1,000 of this maximum amount may be used for covered Services and supplies received from Non-Participating Dentists in a Calendar Year. You pay any amount above the $1,500 Benefit maximum in a Calendar Year.

[2] A 12-month waiting period applies to all Major Services, except as specifically noted under the Waiting Period Exceptions section.

Introduction to the Blue Shield of California Dental PPO Plan 1500-

This PPO Dental Plan is available as an option for Medicare Supplement Subscribers. Termination of your Medicare Supplement Agreement will cause the termination of this Agreement.

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

Before Obtaining Dental Services

You are responsible for assuring that the Dentist you choose is a Participating Dentist. Note: A Participating Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dentist, in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located in your area, can be obtained by contacting a contracted Dental Plan Administrator at 1-888-679-8928. You may also access a list of Participating Dentists through Blue Shield of California's internet site located at http://www.blueshieldca.com. You are also responsible for following the Pre-certification of Dental Benefits Program that includes obtaining or assuring that the Dentist obtains Pre-certification of Benefits.

NOTE: A contracted Dental Plan Administrator will respond to all requests for pre-certification and prior authorization within 5 business days from receipt of the request. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Person or when the Person is experiencing severe pain, a contracted Dental Plan Administrator will respond within 72 hours from receipt of the request.

Failure to meet these responsibilities may result in the denial of benefits. However, by following the Pre-certification process both you and the Dentist will know in advance which services are covered and the benefits that are payable.

The Blue Shield of California Dental PPO Plan is specifically designed for you to use Participating Dentists. Participating Dentists agree to accept a contracted Dental Plan Administrator's payment plus your payment of any applicable Deductible and Copayment, as payment in full for covered services. This is not true of Non-Participating Dentists.

If you go to a Non-Participating Dentist, you will be reimbursed up to a pre-determined maximum amount for covered services by that Non-Participating Dentist. Your reimbursement may be substantially less than the billed amount. The Subscriber is responsible for all differences between the amount you are reimbursed and the amount billed by Non-Participating Dentists. It is therefore to your advantage to obtain dental services from Participating Dentists.

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

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

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

Continuity of Care by a Terminated Provider

Persons who are being treated for acute dental conditions, serious chronic dental conditions, or who have received authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving a contracted Dental Plan Administrator's network of Participating Dentists. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services

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

Conditions of Coverage

Enrollment of a Subscriber

1. Enrollment in this Plan is only available to Subscribers in a Blue Shield of California Medicare Supplement Plan.
2. Enrollment of Subscribers is not effective until Blue Shield of California approves an application and accepts the applicable Dues. Applications can only be approved by Blue Shield of California's Underwriting Department.
3. An applicant, upon completion and approval by Blue Shield of California of the application, is entitled to the benefits of this Agreement upon the Effective Date.

Duration of the Agreement

This Agreement shall be renewed upon receipt of pre-paid Dues. Renewal is subject to the provisions of the: Conditions of Coverage section entitled Renewal of the Agreement and to Blue Shield of California's right to amend this Agreement. Any change in Dues or benefits are effective after 60 days notice to the Subscriber's address of record with Blue Shield of California.

Termination / Reinstatement of the Agreement following Termination for Non-Payment of Dues

This Agreement may be rescinded or terminated as follows:

1. Termination by the Subscriber
   A Subscriber desiring to terminate this Agreement shall give Blue Shield of California 30 days written notice.

2. Rescission by Blue Shield of California.
   By signing the enrollment application, you represented that all responses contained in your application for coverage were true, complete and accurate, to the best of your knowledge, and you were advised regarding the consequences of intentionally submitting materially false or incomplete information to Blue Shield of California in your application for coverage, which included rescission of this Agreement.

   To determine whether or not you would be offered enrollment through this Agreement, Blue Shield of California reviewed your medical history based on the information you provided in your enrollment application, including the health history portion of your enrollment application and any supplemental information that Blue Shield of California determined was necessary to evaluate your medical history and status. This process is called medical underwriting.

   Blue Shield of California has the right to rescind this Agreement if the information contained in the application or otherwise provided to Blue Shield of California by you or anyone acting on your behalf in connection with the application was intentionally and materially inaccurate or incomplete. This

Agreement also may be rescinded if you or any one acting on your behalf failed to disclose to Blue Shield of California any new or changed facts arising after the application was submitted but before this Agreement was issued, when those facts pertained to matters inquired about in the application. However, after 24 months following the issuance of the Agreement, Blue Shield of California will not rescind the Agreement for any reason.

If after enrollment, Blue Shield of California investigates your application information, we will not rescind this Agreement without first notifying you of the investigation and offering you an opportunity to respond. If this Agreement is rescinded, it means that the Agreement is voided retroactive to its inception as if it never existed. This means that you will lose coverage back to the original Effective date. If the Agreement is properly rescinded, Blue Shield of California will refund any Dues payments you made, but, to the extent permitted by applicable law, may reduce that refund by the amount of any medical expenses that Blue Shield of California paid under the Agreement or is otherwise obligated to pay. In addition, Blue Shield of California may, to the extent permitted by California law, be entitled to recoup from you all amounts paid by Blue Shield of California under the Agreement.

If this Agreement is rescinded, Blue Shield of California will provide a 30 day advance written notice that will: (a) explain the basis of the decision and your appeal rights, including your right to request assistance from the California Department of Managed Health Care; (b) clarify that those members whose application information was not false or incomplete are entitled to new coverage without medical underwriting, and will explain how those members may obtain this coverage; and (c) explain that the monthly dues for those members will be determined based on the number of members that remain as Blue Shield of California members.

3. Termination by Blue Shield of California through cancellation:
   Blue Shield of California may cancel this Agreement immediately upon written notice for the following reasons:

   a. Fraud or deception in obtaining, or attempting to obtain, benefits under this Agreement.

   b. Knowingly permitting fraud or deception by another person in connection with this Agreement, such as, without limitation, permitting someone else to seek benefits under this Agreement, or improperly seeking payment from Blue Shield of California for benefits provided.

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

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

   e. Rescission of this Agreement otherwise would be permitted under California law, but rescission of this Agreement would not be permitted under Federal law.

   Cancellation of the Agreement under this section will terminate the Agreement 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 Agreement.

4. Termination by Blue Shield of California if Subscriber moves out of service area:
   Blue Shield of California may cancel this Agreement upon thirty (30) days written notice if the Subscriber moves out of California.

Within 30 days of the notice of cancellation under sections 3 or 4, above, Blue Shield of California shall refund the prepaid Dues, if any, that Blue Shield of California determines will not have been earned as of the termination date. Blue Shield of California reserves the right to subtract from any such Dues refund any amounts paid by Blue Shield of California for benefits paid or payable by Blue Shield of California after the termination date.

5. Termination by Blue Shield of California due to withdrawal of the Agreement from the market:

   Blue Shield of California may terminate this Agreement together with all like Agreements to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll on any other individual agreement without regard to health-status-related factors.

6. Cancellation by Blue Shield of California for Subscriber's Nonpayment of Dues:

   a. Blue Shield of California may cancel this Agreement for failure to pay the required Dues, when due. If the Agreement is being cancelled because you failed to pay the required Dues when due, then coverage will end 30 days after the date for which the Dues are due. You will be liable for all Dues accrued while this Agreement continues in force including those accrued during this 30 day grace period.

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

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

   b. The specific date and time when your coverage ended.

7. Reinstatement of the Agreement after Termination for Non-Payment:

   If the Agreement is cancelled for nonpayment of Dues, Blue Shield of California will permit reinstatement of the Agreement or coverage twice during any twelve-month period, without a change in Dues 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 Agreement is cancelled for nonpayment of Dues more than twice during the preceding twelve-month period, then Blue Shield of California is not required to reinstate you, and you will need to re-apply for coverage. In this case, Blue Shield of California may impose different Dues and consider your medical condition.

Renewal of the Agreement

Blue Shield of California shall renew this Plan, except under the following conditions:

1. Non-payment of Dues;

2. Fraud, misrepresentation, or omission of information on the application;

3. Termination of plan type by Blue Shield of California;

4. Termination of the Subscriber's Medicare Supplement coverage.

Pre-certification of Dental Benefits

Before any course of treatment expected to cost more than $250 is started, you should obtain Pre-certification of Benefits. Your Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic X-rays to a contracted Dental Plan Administrator. A contracted Dental Plan Administrator will review the

dental treatment plan to determine the benefits payable under the plan. The benefit determination for the proposed treatment plan will then be promptly returned to the Dentist. When the treatment is completed, your claim form should be submitted to a contracted Dental Plan Administrator for payment determination. A contracted Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

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

Failure to obtain Pre-certification of Benefits may result in a denial of benefits.

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

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

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

Payment

PLEASE READ THE FOLLOWING SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS, HEALTH CARE MAY BE PROVIDED.

Participating Dentists

When you receive covered dental services from a Participating Dentist, the Participating Dentist will file claims on your behalf and will be reimbursed at the applicable payment percentage as outlined under the Blue Shield of California Payment Percentage section in the Summary of Benefits. Subscribers are responsible for the remaining percentage amount. Copayments are based on the Allowable Amount.

Services rendered for Diagnostic and Preventive Care will be paid at 100%, subject to certain limitations as specified in the section entitled COVERED SERVICES AND SUPPLIES.

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

If the covered person recovers from a third party the reasonable value of covered services rendered by a Participating Dentist, the Participating Den-

tist who rendered these services is not required to accept the fees paid by a contracted Dental Plan Administrator as payment in full, but may collect from the covered person the difference, if any, between the fees paid by a contracted Dental Plan Administrator and the amount collected by the covered person for these services.

Non-Participating Dentists

When you receive covered services from a Non-Participating Dentist, you will be reimbursed up to the applicable percentage as specified in the Blue Shield of California Payment Percentage section in the Summary of Benefits. You will be responsible for the remaining percentage amount plus the remainder of the Dentist's billed charges. You should discuss this beforehand with your Dentist if he is not a Participating Dentist. Any difference between a contracted Dental Plan Administrator's or Blue Shield of California's payment and the Non-Participating Dentist's charges are your responsibility. Subscribers are expected to follow the billing procedures of the dental office.

If your receive covered Services from a Non-Participating Dentist, either you or your provider may file a claim using the dental claim form which may be obtained by calling Dental Customer Services at:

1-888-679-8928

Claims for all Services rendered by Non-Participating Dentists, should be sent to:

Blue Shield of California
P O Box 272590
Chico, CA 95927-2590

Calendar Year Deductible per person

Except as noted, the Calendar Year Deductible applies to all covered Services and supplies furnished by Participating and Non-Participating Dentists [1]. It is the amount that you must pay out of pocket before benefits will be provided for covered Services. This Deductible applies separately to each covered Person each Calendar Year.

[1] The Calendar Year Deductible does not apply to those dental Services considered by Blue Shield of California to be Diagnostic or Preventive. Please see the Summary of Benefits for additional information.

Maximum Blue Shield of California Calendar Year Payment

The maximum payment each Calendar Year for covered Services by any combination of Participating and Non-Participating Dentists is shown in the Summary of Benefits. No benefits in excess of this amount will be provided to or on behalf of any Person.

Procedures for Filing a Claim

Claims for covered dental services should be submitted on a dental claim form which may be obtained from a contracted Dental Plan Administrator, or any Blue Shield of California Office. Have your Dentist complete the form and mail it to a contracted Dental Plan Administrator.

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

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

Covered Services and Supplies

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

The following services are Benefits when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice.

These Benefits are subject to the general limitations and exclusions of the Plan. Payments are subject to the dental benefit Deductible and to the payment percentages indicated in the section entitled Summary of Benefits.

Diagnostic and Preventive Services

Diagnostic and Preventive Services provided by Participating Dentists will be covered at 100%, subject to the General Limitations section and are not subject to the Calendar Year Deductible.

Clinical oral examinations, - excluding emergency examinations, not more than once in any period of six (6) consecutive months.

Dental prophylaxis - not more than once in any period of four (4) consecutive months. (Prophylaxes performed in conjunction with fluoridation or any other procedure and periodontal prophylaxes shall be considered as being a prophylaxis for the purpose of applying this limitation.)

X-rays - Bitewing films not more than once in any period of six (6) consecutive months. Full mouth series (includes 10 to 14 periapical X-rays and supplementary bitewing films) not more than once in any period of thirty-six (36) consecutive months. In applying this thirty-six (36) month limitation, a panoramic X-ray shall be considered a full mouth series. X-rays required to diagnose a specific condition that needs treatment are not subject to the limitations stated above.

Diagnostic casts not more than once in any period of sixty (60) consecutive months. Working models taken in conjunction with a prosthetic or other appliance are not considered to be diagnostic casts.

Basic Services

Anesthesia — General, or intravenous sedation only when provided in conjunction with a covered oral surgical procedure.

Palliative — Emergency treatment for relief of pain and sedative filling; other non-pain producing emergent services, including recementation of inlay, onlay or partial coverage restoration, recementation of cast or prefabricated post and core, recementation of crown, and recementation of fixed partial denture.

Basic Restorative Services – Amalgam restorations; synthetic restorations (i.e. silicate cement filling, porcelain filling, plastic filling and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material.

Major Services

These Services are covered after twelve months of continuous coverage under the plan, except as noted under the Waiting Period Exceptions section below.

Refer to the section entitled Summary of Benefits for Blue Shield of California's payment percentage.

Endodontics — Pulp capping; including pulpotomy or other palliative treatment and necessary X-rays and cultures, but excluding final restoration; root canal therapy; apicoectomy (including apical curettage).

Oral Surgery — Extractions; removal of impacted teeth, radical excision of small (to 1.25 cm) non-malignant lesions; other surgical procedures; includes local anesthesia and routine pre and postoperative care.

Periodontics — Emergency treatment including but not limited to periodontal abscess and acute periodontitis; root planing (not prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post-surgical visits.

Prosthetics — Bridges, dentures, partials and relining or re-basing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stayplate, special tissue conditioning per denture (limited to one course of

treatment per six (6) month period), and denture duplication (jump case).

Replacement of complete or partial dentures, fixed bridgework or crowns previously covered by the Plan due to loss or theft within sixty (60) months after initial or supplemental placement. This also applies to the damage of any prostheses that is not directly related to faulty lab work. "Prostheses" include retainers, habit appliances and any fixed or removable interceptive orthodontic appliances as well as fixed and removable bridgework.

Replacement of dentures (complete or partial), crowns or fixed bridgework due to provider error. The provider is financially responsible for comparable replacement. If replacement is warranted because of an action by, or the non-compliance of, the patient, that patient is financially liable for replacement of the prosthesis (this includes decay or periodontal disease directly related to patient non-compliance). The Plan will pay for a replacement in this instance after the sixty (60) months waiting period from initial placement has elapsed.

Denture relines (either complete or partial conventional dentures) within six (6) months after insertion of the prosthesis. This service is covered once every twelve months following initial insertion or reline. In the case of immediate full or partial dentures, the final reline must be performed no sooner than eight weeks after tooth extractions and denture insertion. Chair-side tissue conditioners can be used for temporary relief of discomfort and/or to increase retention and be considered palliative treatment. Relines for immediate full and partial dentures will not be covered within two (2) weeks of tooth extraction and prosthesis insertion. One reline for each prosthesis is included in the immediate denture fee between two (2) and six (6) months following insertion.

Cast Restorations — Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a filling material. Cast restorations (inlays, on-lays, and other laboratory prepared restorations); crowns (acrylic, composite glass, porcelain and gold); post and cores; crown buildups (on vital or non-vital teeth when functionally necessary). There is no coverage for replacement of an existing crown, inlay or onlay, or other cast restoration which is less than five (5) years old and can be repaired. Repair and re-cementing of inlays, onlays and crowns, is covered for six (6) months after installation.

Waiting Period Exceptions

When there is documentation that any of the conditions below existed at the time treatment was begun, or emergent conditions existed during preparation of a specific tooth, the applicable 12-month waiting period will be waived, subject to review of documentation by a Plan dental director.

Benefits will be provided for specific dental procedures necessary to treat specified emergent, painful or infective acute dental conditions in a manner consistent with professionally recognized standard of care. The Plan reserves the right to administratively review, by a Plan dental director, the submitted documentation of the above conditions for coverage determination.

Conditions characterized by acute pain or infection include the following:

- Acute pain requiring immediate root canal;
- Acute pain requiring tooth extraction or removal and/or incision and drainage;
- Acute periodontal abscess requiring emergency periodontal procedures.

Emergent restorative conditions include the following:

- A tooth that is undergoing restoration that was begun as a (Basic Restorative) filling, but due to the extent of decay/fracture found during the course of its restoration, is now required to have a (Major Restorative) cast crown placed.

General Exclusions and Limitations

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 of California 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 of California 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. 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 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;
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;
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. 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. Services for which the Member 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;
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. Charges for any inlay restoration;
27. Charges for dental appointments which are not kept;
28. Charges for services incident to any intentionally self-inflicted injury;
29. 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 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 Dental Necessity.

    A contracted Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Dental Necessity;
30. 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;
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. 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;
33. 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.

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

Dental Necessity Exclusion
All Services must be of Dental Necessity. The fact that a Dentist or other provider may prescribe, order, recommend, or approve a service does not, in itself, make it of Dental 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 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 four (4) per year):
   c. 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;
3. One (1) in twelve (12) month period:
   a. Denture (complete or partial) reline.
   b. Oral cancer screening.
4. One in twenty-four (24) months:
   a. Full mouth debridement;
   b. Scaling and root planning per area (limited to 2 quadrants per visit;
   c. Occlusal guards
   d. Diagnostic casts
5. One 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;
   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;
7. Oral surgery services are limited to removal of teeth, bony protuberances and frenectomy.
8. 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 he 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 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.
9. General or IV Sedation is covered for:
   a. 3 or more surgical extractons;
   b. any number of dentally necessary impactions;

c. Full mouth or arch alveoloplasty;

d. Surgical root recovery from sinus;

e. Medical problem contraindicates the use of local anesthesia;

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

10. Restorations, crowns, inlays 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.

Exception for Other Coverage

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

Reductions

Third-Party Liability — If a covered Person is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield of California shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield of California paid for the Services provided to the covered Person on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Subscriber, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

Blue Shield of California's right to restitution, reimbursement or other available remedy is against any recovery the Subscriber received as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Subscriber has been "made whole" by the Recovery. Blue Shield of California's right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due Blue Shield of California for the Benefits it paid in connection with such injury or illness, calculated in accordance with California Civil Code section 3040.

The covered Person is required to:

1. Notify a contracted Dental Plan Administrator or Blue Shield of California in writing of any actual or potential claim or legal action which such covered person expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than thirty 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate with a contracted Dental Plan Administrator or Blue Shield of California to execute any forms or documents needed to enable Blue Shield of California or a Dental Plan Administrator to effect restitution, reimbursement or other available remedies; and,

3. Agree in writing to reimburse Blue Shield of California for Benefits paid by Blue Shield of California from any Recovery when the Recovery is obtained from or on behalf for the third party, or from uninsured or underinsured motorist coverage; and,

4. Provide a contracted Dental Plan Administrator or Blue Shield of California with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield of California, in writing, within ten (10) days after any Recovery has been obtained.

A covered Person's failure to comply with 1 through 5, above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield of California.

Emergency Services

Emergency Services include Covered Services to alleviate severe pain or other symptoms or for the diagnosis and treatment of an unforeseen illness or injury that a reasonable person under the circumstances would believe if not treated immediately could lead to serious jeopardy of health or impairment. The determination of whether the situation required Emergency Services will be made retrospectively by a contracted Dental Plan Administrator based upon an objective review that is consistent with professionally recognized standards of care.

Based on the Dental Administrator's review, any applicable waiting period will be waived for Emergency dental conditions.

If a Subscriber receives Emergency care outside of California, you will be reimbursed at the payment percentage listed under the Non-Participating Dentist portion of the Summary of Benefits. The Subscriber will be responsible for the remainder of the Dentist's Billed Charges. Whenever possible, the Subscriber should ask the Dentist to bill the Plan directly.

Payment or reimbursement of Emergency Services provided to a Subscriber will be made after a contracted Dental Plan Administrator receives documentation of the charges incurred and upon approval by a contracted Dental Plan Administrator of those charges set forth. Except for Emergency care, as noted above, a Subscriber will be responsible for full payment of dental services rendered outside of California. A contracted Dental Plan Administrator will notify the Subscriber of its determination within 30 days from receipt of the claim.

Dues

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

Please call Customer Service at 1-888-679-8928 to discuss these options or visit the Blue Shield of California internet site at http:///www.blueshieldca.com.

Payments by mail are to be sent to:

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

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

General Provisions

Claims and Services Review

Blue Shield of California and a contracted Dental Plan Administrator reserve the right to review all claims and services to determine if any exclusion or other limitations apply. Blue Shield of California or a contracted Dental Plan Administrator may use the service of Dentist consultants, peer review committees or professional societies, and other consultants to evaluate claims.

Liability of Subscribers in the Event of Non-Payment by Blue Shield of California

In accordance with Blue Shield of California's established policies, and by statute as of 1975, every contract between a contracted Dental Plan Administrator and its Participating Dentists stipulates that the Subscriber shall not be responsible to the Participating Dentist for compensation for any Covered Services to the extent that they are provided in the Subscriber's medical policy. When Services are provided by a Participating Dentist, the Subscriber is responsible for any applicable Deductible or Copayment and charges in excess of Benefit maximums.

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

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

Entire Agreement: Changes

This Agreement, including the appendices, constituted the entire Agreement between parties. Any statement made by a Person shall, in the absence of fraud, be deemed a representation and not a warranty. No changes in this Agreement shall be valid unless approved by a corporate officer of Blue Shield of California and a written endorsement issued. No representative has authority to change this Agreement or to waive any of its provisions.

Choice of Providers

Under this Plan, you have a free choice of any licensed Dentist including such providers outside of California.

Facilities (Participating Providers)

The names of Participating Dentists in your area may be obtained by contacting a contracted Dental Plan Administrator at 1-888-679-8928.

Notices

Any notice required by this Agreement may be delivered by United States mail, postage pre-paid. Notice to the Subscriber may be mailed to the address appearing on the records of Blue Shield of California and notice to Blue Shield of California may be mailed to:

Blue Shield of California
50 Beale Street
San Francisco, CA 94105

Independent Contractors

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

Endorsements and Appendices

Attached to and incorporated in this Agreement by reference are appendices pertaining to Dues. Endorsements may be issued from time to time subject to the notice provisions of the section entitled ***Duration of the Agreement***. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

Identification Cards

Identification (ID) cards will be issued by Blue Shield of California to all Subscribers.

Grace Period

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

Commencement or Termination of Coverage

Wherever this Agreement provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective as of 12:01 a.m. Pacific Time of that the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

Statutory Requirements

This Agreement is subject to the Knox-Keene Health Care Services Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and to Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such laws shall be binding upon Blue Shield of California whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations, which may include the Health Insurance Portability and Accountability Act. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield of California whether or not such provision is actually included in this Agreement.

Legal Process

Legal process or service upon Blue Shield of California must be served upon a corporate officer of Blue Shield of California.

Non-Assignability

Coverage or any benefits of this Agreement may not be assigned without the written consent of Blue Shield of California.

Possession of a Blue Shield of California Identification (ID) Card confers no right to Services or other benefits of this Agreement. To be entitled to Services, the Person must be a Subscriber who has maintained enrollment under the terms of this Agreement.

The coverage and Benefits of this Plan are assignable to Participating and Non-Participating Dentists.

Commencement of Legal Action

Any suit or action to recover benefits under this Agreement, or damages concerning the provision of coverage or benefits, the processing of claims, or any other matter arising out of this Agreement, shall be commenced no later than two (2) years after the date of coverage for benefits in question were first denied, unless a shorter period of limitations otherwise applies.

Utilization Review

State law requires that health plans disclose to Subscribers and health plan providers the process used to authorize or deny health care services under the plan. Blue Shield of California 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 Customer Service Department at 1-888-679-8928.

Notice

The Subscriber hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Subscriber and Blue Shield of California, which is an independent corporation operating under a license from the Blue Cross Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting Blue Shield of California to use the Blue Shield Service Mark in the State of California and that Blue Shield of California is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than the Plan and no person, entity, or organization other than Blue Shield of California shall be held accountable or liable to the Subscriber for any of Blue Shield of California's obligations to the Subscriber created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Shield of California, other than those obligations created under other provisions of this Agreement.

Dental Customer Services

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

1-888-679-8928
Dental Plan Administrator
Dental Customer Service
425 Market Street, 12th Floor
San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

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

dence of Coverage and Health Service Agreement.

Note: A contracted Dental Plan Administrator has established a procedure for our Subscribers to request an expedited decision. A Subscriber, Physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. A contracted Dental Plan Administrator shall make a decision and notify the Subscriber and Physician within 72 hours following the receipt of the request. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the Dental Customer Service Department at the number listed above.

Grievance Process

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

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

1-888-679-8928
Blue Shield of California
Dental Plan Administrator
425 Market Street, 12th Floor
San Francisco, CA 94105

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

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

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health plan at the number listed on the last pages of this booklet and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms, and instructions online.

In the event that Blue Shield of California should cancel or refuse to renew the enrollment for you and you feel that such action was due to reasons of health or utilization of Benefits, you 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 of California will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield of California'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 of California's Internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield of California 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 Number:
1-888-266-8080

E-mail Address:
blueshieldca_privacy@blueshieldca.com

Access to Information

Blue Shield of California may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Agreement. You agree that any provider or entity can disclose to Blue Shield of California that information that is reasonably needed by Blue Shield of California. You agree to assist Blue Shield of California in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield of California with information in your possession. Failure to assist Blue Shield of California in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield of California will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Public Participation Procedure

This procedure enables you to participate in establishing public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure complaints, inquiries or requests for information.

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

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

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

Procedure

Your recommendations, suggestions, or comments should be submitted in writing to the Sr. Manager, Regulatory Filings at the above address, who will acknowledge receipt of your letter.

Your name, address, phone number, Subscriber number, and group number should be included with each communication.

The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter.

Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within ten business days after the minutes have been approved.

Definitions

Whenever the following definitions are capitalized in this booklet, they will have the meaning stated below.

Agreement - this Evidence of Coverage and Health Service Agreement, any endorsements issued by Blue Shield of California to this Agreement, and the Subscriber's application.

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 a Subscriber is entitled to receive pursuant to the terms of this Agreement.

Billed Charges — the prevailing rates of the Dental office.

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

Copayment — an amount which a Subscriber is required to pay for certain Benefits.

Covered Services (Benefits) — those Services which a Subscriber is entitled to receive pursuant to the terms of this Agreement.

Deductible means the amount paid by the Subscriber for specific covered Services before the Blue Shield of California Dental PPO Plan begins to pay.

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

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.

Dentist — a duly licensed Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM) or other practitioner who is legally entitled to practice dentistry in the state of California.

Dues — the pre-payment that is made to the Plan on behalf of each Subscriber.

Effective Date – the date on which an Applicant, who has met the enrollment and prepayment requirements of this Agreement, is accepted by Blue Shield of California as a Subscriber. The Effective Date for any Endorsement shall be the same unless otherwise stated.

Elective Dental Procedure — any dental procedures which are unnecessary to the dental health of the patient, as determined by a contracted Dental Plan Administrator.

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.

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.

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).

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

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

Person —a Subscriber.

Plan — the Blue Shield of California Dental PPO Plan.

Prosthesis — an artificial part, appliance, or device used to replace a missing part of the body.

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

Subscriber — a person whose status is the basis for eligibility for membership in this Plan, who is enrolled by Blue Shield of California and maintains coverage in accordance with this Agreement.

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.

IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Office, to take effect on the Subscriber's effective date.

John Hedberg, Vice President – Senior Markets
Individual, Small Group and Government Business Unit
Blue Shield of California

Dental Customer Service Telephone Numbers:

Blue Shield of California
Dental Plan Administrator
1-888-679-8928

Dental Customer Service Correspondence Address:

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

Claims for all Covered Services should be sent to:

Blue Shield of California
P. O. Box 2722590
Chico, CA 95927-2590

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