Pediatric Dental HMO Plan

Evidence of Coverage

Group
About this Pediatric Dental Plan:  This plan provides pediatric oral care coverage to meet the essential health benefits requirements of the Affordable Care Act. This dental plan is part of a package that consists of a health plan and a dental plan which is offered at a package rate. This Evidence of Coverage describes the Benefits of the dental plan as part of the package. Benefits of this pediatric dental plan are provided only to Members under the age of 19.

NOTICE
This Evidence of Coverage booklet describes the terms and conditions of coverage of your Blue Shield dental Plan. It is your right to view the Evidence of Coverage prior to enrollment.

Please read this Evidence of Coverage carefully and completely so that you understand which services are covered and the terms and conditions that apply to your Plan. If you or your dependents have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

At the time of your enrollment, Blue Shield of California provides you with a Matrix summarizing key elements of the Blue Shield of California Group Health Plan you are being offered. This is to assist you in comparing group health plans available to you.

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Member Services at the address or telephone number listed in the Member Services paragraphs of the Other Provisions section of this booklet.

IMPORTANT
No person has the right to receive the Benefits of this Plan for services or supplies furnished following termination of coverage, except as specifically provided under, when applicable, the Group Continuation Coverage provision in this booklet.

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 group contract.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the group contract. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.

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 1-800-286-7401 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.
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I. **INTRODUCTION TO THE BLUE SHIELD PEDIATRIC DENTAL HMO PLAN**

Your interest in the Blue Shield Pediatric Dental HMO Plan is truly appreciated. Blue Shield has been serving Californians for over 60 years, and we look forward to serving your dental care needs.

You will have the opportunity to be an active participant in your own dental care. The Blue Shield Pediatric Dental HMO Plan will help you make a personal commitment to maintaining and, where possible, improving your dental health status. Like you, we believe that maintaining a healthy lifestyle and preventing dental illness are as important as caring for your needs when dental problems arise.

Please review this booklet which summarizes the coverage and general provisions of the Blue Shield Pediatric Dental HMO Plan.

Blue Shield of California’s dental plans are administered by a contracted Dental Plan Administrator (DPA).

If you have any questions regarding the information in this booklet, need assistance, or have any problems, you may contact Blue Shield or your dental Member Services Department 800-286-7401.

II. **EVIDENCE OF COVERAGE STATEMENT**

This Evidence of Coverage booklet constitutes only a summary of the Plan. The Dental Contract must be consulted to determine the exact terms and conditions of coverage. The Dental Services Contract is available through your employer or a copy can be furnished upon request. Your employer is familiar with this Plan, and you may also direct questions concerning Covered Services or specific Plan provisions to the Blue Shield Plan Member Services Department.

III. **CHOICE OF DENTAL PROVIDER**

**SELECTING A DENTAL PROVIDER**

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

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

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

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

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

**CHANGING DENTAL PROVIDERS**

You or a Dependent may change Dental Providers without cause at the following times:

1. during open enrollment;
2. when your change in residence makes it inconvenient to continue with the same Dental Provider;
3. one other time during the Calendar Year.

If you want to change Dental Providers at any of the above times, you must contact Dental Member Services. Before changing Dental Providers you must pay any outstanding Copayment balance owed to your existing Dental Provider. The change will be effective the first day of the month following notice of approval by the Plan.

If your Dental Provider ceases to be in the Plan Provider network, the Plan will notify you in writing. To ensure continuity of care you will temporarily be assigned to an alternate Dental Provider and asked to select a new Dental Provider. If you do not select a new Dental Provider within the specified time, your alternate Dental Provider assignment will remain in effect until you notify the Plan of your desire to select a new Dental Provider.

**CONTINUITY OF CARE BY A TERMINATED PROVIDER**

Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving a contracted Dental Plan Administrator’s Plan Provider Network. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.
CONTINUITY OF CARE FOR NEW MEMBERS BY NON-CONTRACTING PROVIDERS

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

PAYMENT OF PROVIDERS

Blue Shield contracts with a contracted Dental Plan Administrator to provide Services to our Members. A monthly fee is paid to a contracted Dental Plan Administrator for each Member. This payment system includes incentives to a contracted Dental Plan Administrator to manage all Covered Services provided to Members in an appropriate manner consistent with the Contract.

Your Dental Provider must obtain authorization from a contracted Dental Plan Administrator before referring you to providers outside of the Dental Center.

If you want to know more about this payment system, contact a contracted Dental Plan Administrator at the number shown in the Member Services section of this booklet or talk to your Plan Provider.

RELATIONSHIP WITH YOUR DENTAL PROVIDER

The Dentist-patient relationship you establish with your Dental Provider is very important. The best effort of your Dental Provider will be used to ensure that all Medically Necessary and appropriate professional Services are provided to you in a manner compatible with your wishes.

If your Dentist recommends procedures or treatment which you refuse, or you and the Dental Provider fail to establish a satisfactory relationship, you may select a different Dental Provider. The Plan Member Services can assist you with this selection.

Your Dental Provider will advise you if they believe there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the recommended treatment or procedure, the Plan Member Services can assist you in the selection of another Dental Provider.

Repeated failures to establish a satisfactory relationship with a Dental Provider may result in termination of your coverage, but only after you have been given access to other available Dental Providers and have been unsuccessful in establishing a satisfactory relationship. Any such termination will take place in accordance with written procedures established by Blue Shield and only after written notice to the Member which describes the unacceptable conduct, provides the Member with an opportunity to respond and warns the Member of the possibility of termination.

IV. HOW TO USE YOUR DENTAL PLAN

USE OF DENTAL PROVIDER

At the time of enrollment, you will choose a Dental Provider that will provide and coordinate all covered dental Services. You must contact your Dental Provider for all dental care needs including preventive Services, routine dental problems, consultation with Plan Specialists and Emergency Services. The Dental Provider is responsible for providing general Dental Care Services and coordinating or arranging for referral to other necessary Plan Specialists. The Plan must authorize such referrals.

To avoid a failed/broken appointment charge, you must always cancel any scheduled appointments at least 24 hours in advance.

To obtain Benefits under your Plan, you must attend the Dental Provider you selected. If for any reason you did not select a Dental Provider, contact Member Services at 800-286-7401.

REFERRAL TO PLAN SPECIALISTS

All specialty Dental Care Services must be provided by or arranged for by the Dental Provider. Referral by a Dental Provider does not guarantee coverage for the services for which the Member is being referred. The Benefit and eligibility provisions, exclusions, and limitations will apply. Members may be referred to a Plan Specialist within the Dental Center. However, you may also be referred to a Plan Specialist outside of the Dental Center if the type of Specialty Service needed is not available within your Dental Center.

If the Dental Provider determines specialty Dental Care Services are necessary, they will complete a referral form and notify a contracted Dental Plan Administrator. A contracted Dental Plan Administrator then must authorize such referrals. When no Plan Dentist is available to perform the needed Service, the Dental Provider will refer you to a non-Plan dentist after obtaining Authorization from a contracted Dental Plan Administrator. This Authorization procedure is handled for you by your Dental Provider.

Generally, your Dental Provider will refer you within the network of Blue Shield Plan Specialists in your area. After the Specialty Services have been rendered, the Plan Specialist will provide a complete report to your Dental Provider to ensure your dental record is complete.
EMERGENCY SERVICES

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

For Emergency Services within your Service Area you should first notify your Dental Provider to obtain care, authorization, or instructions for care prior to actual Emergency treatment. If it is not possible to notify your Dental Provider prior to receiving Emergency Services, you must notify your Dental Provider within 24 hours after care is received unless it was not reasonably possible to communicate within this time limit. In such case, notice must be given as soon as possible. Failure to provide notice as stated may result in the services not being covered.

If you are in need of emergency treatment and are outside the geographic area of your designated Dental Provider, you should first contact a contracted Dental Plan Administrator to describe the emergency and receive referral instructions. If a contracted Dental Plan Administrator does not have a contracted dentist in the area, or if you are unable to contact a contracted Dental Plan Administrator, you should contact a dentist of your choice. Emergency treatment refers only to those dental services required to alleviate pain and suffering. You will be directly reimbursed for this treatment up to the maximum allowed under your Plan Benefits. Refer to the section titled “Responsibility for Co-payments, Charges for non-Covered Services and Emergency Claims” within the insert.

NOTE: A contracted Dental Plan Administrator will respond to all requests for prior authorization of services as follows:

- for urgent services, as soon as possible to accommodate the Member’s condition not to exceed 72 hours from receipt of the request;
- for other services, within 5 business days from receipt of the request.

If you obtain services without prior Authorization from a contracted Dental Plan Administrator, a contracted Dental Plan Administrator will retrospectively review the services for coverage as Emergency Services. If a contracted Dental Plan Administrator determines that the situation did not require Emergency Services, you will be responsible for the entire cost of the services. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

LIMITATION OF MEMBER LIABILITY

Members shall not be responsible to Plan Providers for payment of a Service if the Service is a Benefit of the Plan. When Covered Services are rendered by a Plan Dentist, the Member is responsible only for the applicable Copayments and charges in excess of Benefit maximums. Members are responsible for the full charges for any non-covered services they obtain.

If a Dental Provider ceases to be in the Plan Provider network, you will be notified if you are affected. The Plan will make every reasonable and appropriate provision to have another Dental Provider assume responsibility for your dental care. Once provisions have been made for the transfer of your care, services of a former Plan Dentist are no longer covered, except as provided under Section III., Choice of Dental Provider, Continuity of Care by a Terminated Provider.

You will not be responsible for payment (other than Copayments) to a former Plan Dentist for any Covered Services you receive prior to the effective date of the transfer to a new Dental Provider.

RESPONSIBILITY FOR COPAYMENTS AND EMERGENCY CLAIMS

Member Responsibility

The Member shall be responsible to the Dental Provider and other Plan Providers for payment of the following charges:

1. Any amounts listed under Copayments in the Dental HMO Summary of Benefits.

2. Any charges for non-covered services.

All such Copayments and charges for non-covered services are due and payable to the Dental Provider or Plan Providers immediately upon commencement of extended treatments or upon the provision of services. Termination of the Plan shall in no way affect or limit any liability or obligation of the Member to the Dental Provider or other Plan Provider for any such Copayments or charges owing.

Emergency Claims

If Emergency Services outside of the Service Area were received and expenses were incurred by the Member, the Member must submit a complete claim with the Emergency Service record (a copy of the Dentist’s bill) for payment to a contracted Dental Plan Administrator, within 1 year after the treatment date.

Please send this information to:
If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not pre-authorized, a contracted Dental Plan Administrator will review the claim retrospectively. If a contracted Dental Plan Administrator determines that the services were not Emergency Services and would not otherwise have been authorized by a contracted Dental Plan Administrator, and, therefore, are not Covered Services under the dental Plan Contract, it will notify the Member of that determination. The Member is responsible for the payment of such Dental Care Services received. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim. If the Member disagrees with a contracted Dental Plan Administrator’s decision, he may appeal using the procedures outlined in the section entitled “Member Services and Grievance Process”.

Out-of-Pocket Maximum

The out-of-pocket maximum per Member for all Covered Services and supplies is specified on the Summary of Benefits. This amount is the most the Member pays during the coverage period (usually one year) for the Member’s share of the cost of covered services. This limit helps the Member plan for dental care expenses.

Member Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments by the Plan for covered Services provided under the Plan.

BLUE SHIELD ONLINE

Blue Shield’s internet site is located at http://www.blueshieldca.com. Members using a personal computer and modem with World Wide Web access may view and download healthcare information and software.

V. PLAN BENEFITS

The Benefits available to you under the Plan are listed in the Summary of Benefits which is incorporated as part of this Evidence of Coverage. Benefits are provided only to Members under the age of 19. The Copayments for these Services, if applicable, are also listed in the Summary of Benefits.

IMPORTANT INFORMATION

The Dental Care Services (Benefits) described in this booklet and its accompanying insert are covered only if they are of Dental Necessity and are provided, prescribed, or referred by your Dental Provider and are approved by a contracted Dental Plan Administrator. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, and to the General Exclusions and Limitations set forth in the General Exclusions and Limitations section of this booklet. A contracted Dental Plan Administrator will not pay charges incurred for services without your Dental Provider’s and/or a contracted Dental Plan Administrator’s prior Authorization except for Emergency Services obtained in accordance with Section IV, How To Use Your Dental Plan.

The determination of whether services are of Dental Necessity or an emergency will be made by a contracted Dental Plan Administrator. This determination will be based upon the Plan's review consistent with generally accepted dental standards, and will be subject to grievance in accordance with the procedures outlined in Section XI, Member Services and Grievance Process.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

VI. 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 for:

1. dental services not appearing on the Summary of Benefits.

2. dental services in excess of the limits specified in the Limitations section of this Evidence of Coverage;

3. services of dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Dental Provider and authorized by the Plan, or when required in a covered emergency;

4. any dental services received or costs that were incurred in connection with any dental procedures started prior to the Member’s effective date of coverage. This exclusion does not apply to Covered Services to treat complications arising from services received prior to the Member’s effective date of coverage;
5. any dental services received subsequent to the time the Member’s coverage ends;

6. experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;

7. dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;

8. procedures, appliances, or restorations to correct congenital or developmental malformations unless specifically listed in the Summary of Benefits;

9. cosmetic dental care;

10. general anesthesia or intravenous/conscious sedation unless specifically listed as a benefit under the Summary of Benefits or is given by a Dentist for a covered oral surgery;

11. hospital charges of any kind;

12. major surgery for fractures and dislocations;

13. loss or theft of dentures or bridgework;

14. malignancies;

15. dispensing of drugs not normally supplied in a dental office;

16. additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist’s office due to the general health and physical limitations of the Member;

17. the cost of precious metals used in any form of dental benefits;

18. surgical removal of implants;

19. services of a pedodontist/pediatric Dentist for Member except when a Member child is unable to be treated by his or her Dental Provider or treatment is Dentally Necessary or his or her Dental Provider is a pedodontist/pediatric Dentist.

20. charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;

21. treatment for any condition for which Benefits could be recovered under any worker’s compensation or occupational disease law, when no claim is made for such Benefits;

22. treatment for which payment is made by any governmental agency, including any foreign government;

23. charges for second opinions, unless previously authorized by the contracted Dental Plan Administrator;

24. 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;

Orthodontic Limitations & Exclusions

Non-medically necessary orthodontia is not a covered Benefit.

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

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 Summary of Benefits, will be subject to Limitations as set forth below. Services identified as optional are not covered. If a Member chooses to receive an optional service, the Member will be responsible for the difference in cost between the Covered Service and the optional service, unless otherwise specified below:

1. Roentgenology (x-rays) are limited as follows:
   a. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
   b. Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
   c. Panoramic film x-rays are limited to once every 24 consecutive months.

2. Prophylaxis services (cleanings) cannot exceed two in a twelve month period.

3. Dental sealant treatments are limited to permanent first and second molars only.

4. Restorations are limited as follows:
   a. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.
   b. Composite resin or acrylic restorations in posterior teeth are optional.
   c. Micro filled resin restorations which are non-cosmetic.
   d. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is Dentally Necessary.

5. Oral Surgery is limited as follows:
   a. Surgical removal of impacted teeth is a Covered Service only when evidence of pathology exists.

6. Endodontics: Retreatment of root canals is a Covered Service only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a Covered Service.

7. Peridontics: Periodontal scaling and root planing and subgingival curettage is limited to five quadrant treatments in any 12 consecutive months.

8. Crowns and Fixed Bridges. Five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction.

Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

   a. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the Dental Plan Administrator.
   b. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
   c. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are
either fractured or decayed to the extent that they will not hold a filling.

d. Veneers posterior to the second bicuspoid are considered optional. An allowance will be made for a cast full crown.

Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

a. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

b. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient’s oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

c. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

d. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

e. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.


a. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

i. Partial dentures are not to be replaced within 36 consecutive months, unless 1) it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or 2) the denture is unsatisfactory and cannot be made satisfactory.

ii. Benefits for partial dentures are limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the Dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

iii. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

iv. Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.

v. Benefits for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the Dentist, the applicant will be responsible for all additional charges.

b. Office or laboratory relines or rebases are limited to one per arch in any 12 consecutive months.

c. Tissue conditioning is limited to two
d. Implants are considered an optional service.

e. Stayplates are a Covered Service only when used as anterior space maintainers for children.

VII. SERVICE AREA AND ELIGIBILITY

SERVICE AREA

The Service Area of this Plan is identified in the Dental HMO 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.

ELIGIBILITY

This Dental HMO Plan provides pediatric oral care coverage to meet the essential health benefits requirements of the Affordable Care Act. Benefits are provided only to Members under the age of 19.

To enroll and continue enrollment, a Subscriber must be an eligible Employee and meet all of the eligibility requirements for coverage established by the Employer. An Employee is eligible for coverage as a Subscriber the day following the date he or she completes the waiting period established by the Employer. The Employee’s spouse or Domestic Partner and all Dependent children are eligible for coverage at the same time.

An Employee or the Employee’s Dependents may enroll when initially eligible or during the Employer’s annual Open Enrollment Period. Under certain circumstances, an Employee and Dependents may qualify for a Special Enrollment Period. Other than the initial opportunity to enroll, the Employer’s annual Open Enrollment period, or a Special Enrollment Period, an Employee or Dependent may not enroll in this dental Plan. Please see the definition of Late Enrollee and Special Enrollment Period in the Definitions section for details on these rights. For additional information on enrollment periods, please contact the Employer or Blue Shield.

Dependent children of the Subscriber, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be eligible immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days, an application must be received by Blue Shield within 60 days from the date of birth, adoption or placement for adoption. If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both. Please contact Blue Shield to determine what evidence needs to be provided to enroll a child.

Enrolled disabled children who would normally lose their eligibility as a Dependent under this dental Plan solely because of age, may be eligible for coverage if they continue to meet the definition of Dependent. See the Definitions section.

The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group dental Plan. If the Employer fails to meet these requirements, this coverage will terminate. See the Termination of Benefits section of this Evidence of Coverage for further information. Employees will receive notice of this termination and, at that time, will be provided with information about other potential sources of coverage, including access to individual coverage through Covered California.

If a Member commits any of the following acts, he or she will immediately lose eligibility to continue enrollment:

1) Abusive or disruptive behavior which:
   a) threatens the life or well-being of Blue Shield personnel, or providers of services;
   b) substantially impairs the ability of Blue Shield to arrange for services to the Member; or
   c) substantially impairs the ability of providers to furnish services to the Member or to other patients.

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

Subject to the requirements described under the Continuation of Group Coverage provision in this Evidence of Coverage, if applicable, an Employee and his or her Dependents will be eligible to continue group coverage under this dental Plan when coverage would otherwise terminate.

EFFECTIVE DATE OF COVERAGE

Blue Shield will notify the eligible Employee/Subscriber of the effective date of coverage for the Employee and his or her Dependents. Coverage starts at 12:01 a.m. Pacific Time on the effective date.

Dependents may be enrolled within 31 days of the Employee’s eligibility date to have the same effective date of coverage as the Employee. If the Employee or Dependent is considered a Late Enrollee, coverage will become effective the earlier of 12 months from the date a written request for coverage is made or at the Employer’s next Open Enrollment Period. Blue Shield will not consider applica-
tions for earlier effective dates unless the Employee or Dependent qualifies for a Special Enrollment Period.

In general, if the Employee or Dependents are Late Enrollees who qualify for a Special Enrollment Period, and the Premium payment is delivered or postmarked within the first 15 days of the month, coverage will be effective on the first day of the month after receipt of payment. If the Premium payment is delivered or postmarked after the 15th of the month, coverage will be effective on the first day of the second month after receipt of payment.

However, if the Late Enrollee qualifies for a Special Enrollment Period as a result of a birth, adoption, guardianship, marriage or Domestic Partnership and enrollment is requested by the Employee within 60 days of the event, the effective date of enrollment will be as follows:

1) For the case of a birth, adoption, placement for adoption, or guardianship, the coverage shall be effective on the date of birth, adoption, placement for adoption or court order of guardianship.

2) For marriage or Domestic Partnership the coverage effective date shall be the first day of the month following the date the request for special enrollment is received.

**PREPAYMENT FEE (PREMIUMS OR DUES)**

The monthly Premiums for a Subscriber and any enrolled Dependents are stated in the Contract. Blue Shield will provide the Employer with information regarding when the Premiums are due and when payments must be made for coverage to remain in effect.

All Premiums required for coverage for the Subscriber and Dependents will be paid by the Employer to Blue Shield. Any amount the Subscriber must contribute is set by the Employer. The Employer’s rates will remain the same during the Contract’s term; the term is the 12-month period beginning with the eligible Employer’s effective date of coverage. The Employer will receive notice of changes in Premiums at least 60 days prior to the change. The Employer will notify the Subscriber immediately.

A Subscriber’s contribution may change during the contract term if the Employer changes the amount it requires its Employees to pay for coverage; (2) if the Subscriber adds or removes a Dependent from coverage; (3) if a Subscriber moves to a different geographic rating region; or (4) if a Subscriber joins the Plan at a time other than during the annual Open Enrollment Period. Please check with Blue Shield or the Employer on when these contribution changes will take effect.

**VIII. DUPLICATE COVERAGE, REDUCTIONS - THIRD PARTY**

**LIABILITY AND COORDINATION OF BENEFITS**

**LIMITATIONS FOR DUPLICATE COVERAGE**

**When you are eligible for Medi-Cal**

Medi-Cal always provides benefits last.

**When you are a qualified veteran**

If you are a qualified veteran your Blue Shield group plan will pay the reasonable value or Blue Shield’s or a contracted Dental Plan Administrator’s Allowed Amount for covered services provided to you at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield group plan will pay the reasonable value or Blue Shield’s or a contracted Dental Plan Administrator’s Allowed Amount for covered services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

**When you are covered by another governmental agency**

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Blue Shield group plan will equal, but not exceed, what Blue Shield or a contracted Dental Plan Administrator would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield’s or a contracted Dental Plan Administrator’s Allowed Amount).

Contact the Member Services department at the number shown in the “Member Services” section of this booklet if you have any questions about how Blue Shield or a contracted Dental Plan Administrator coordinates your group plan benefits in the above situations.

**EXCEPTION FOR OTHER COVERAGE**

A Plan Dentist may seek reimbursement from other third party payers for the balance of its rea-
sonable charges for Services rendered under this Plan.

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

REDUCTIONS - THIRD PARTY LIABILITY
If a Member is injured or becomes ill due to the act or omission of another person (a “third party”), Blue Shield or a contracted Dental Plan Administrator 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 paid for Services provided to the Member from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

This right to restitution, reimbursement or other available remedy is against any recovery the Member receives 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 Member has been “made whole” by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The Member is required to:
1. Notify Blue Shield or a contracted Dental Plan Administrator in writing of any actual or potential claim or legal action which such Member 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 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,

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

4. Provide a lien calculated in accordance with California Civil Code section 3040. 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 and a contracted Dental Plan Administrator, in writing, within ten (10) days after any Recovery has been obtained.

A Member’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 or a contracted Dental Plan Administrator.

COORDINATION OF BENEFITS
Coordination of Benefits is designed to provide maximum coverage for required Dental Care Services at the lowest cost by avoiding excessive payments.

When a person who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for dental expenses, such person will not be permitted to make a “profit” on a disability by collecting Benefits in excess of actual value or cost during any calendar year.
Instead, payments will be coordinated between the plans in order to provide for “allowable expenses” (these are the expenses that are incurred for Dental Care Services covered under at least one of the plans involved) up to the maximum Benefit value or amount payable by each plan separately.

If the Member is also entitled to Benefits under any of the conditions as outlined under the “Limitations for Duplicate Coverage” provision, Benefits received under any such condition will not be coordinated with the Benefits of this Plan.

The following rules determine the order of Benefits payments: When the other plan does not have a coordination of Benefits provision it will always provide its Benefits first. Otherwise, the plan covering the patient as an Employee will provide its Benefits before the plan covering the patient as a Dependent.

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

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent shall determine their respective Benefits in the following order:
   
   First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the step-parent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

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

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

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

2. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its Benefits after the other, then the provisions of (1) above shall not apply.

If this Plan is the primary carrier with respect to a covered person, then this Plan will provide its Benefits without reduction because of Benefits available from any other plan.

When the Plan is secondary in the order of payments, the Plan's benefits are determined after those of the primary plan and may be reduced because of the primary plan’s benefits. In such cases, the Plan pays the lesser of either the amount that it would have paid in the absence of any other coverage, or the enrollee's total out-of-pocket cost payable under the primary plan for benefits covered under the Plan.

When this Plan is secondary in the order of payments, and Blue Shield is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will provide the Benefits that would be due as if it were the primary plan, provided that the covered person (1) assigns to Blue Shield the right to receive payments from the other plan to the extent of the difference between the value of the Benefits which Blue Shield actually provides and the value of the Benefits that Blue Shield would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with Blue Shield and a contracted Dental Plan Administrator in obtaining payment of Benefits from the other plan, and (3) allows Blue Shield and a contracted Dental Plan Administrator to obtain confirmation from the other plan that the Benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another plan, Blue Shield may pay to the other plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as benefits paid under this Plan. Blue Shield shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by Blue Shield in excess of the maximum amount of payment necessary to satisfy these provisions, Blue Shield shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

Blue Shield may release to or obtain from any organization or person any information which Blue Shield considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any person claiming benefits under this Plan shall furnish Blue Shield with such information as may be necessary to implement these provisions.
IX. GROUP CONTINUATION COVERAGE

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Group Continuation Coverage is applicable to Members when the Subscriber’s Employer (Contractholder) is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Subscriber’s Employer should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), a Member will be entitled to elect to continue group coverage under this Plan if the Member would lose coverage otherwise because of a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The Benefits under the group continuation of coverage will be identical to the Benefits that would be provided to the Member if the Qualifying Event had not occurred (including any changes in such coverage).

Note: A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act (“Medicare”) or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any pre-existing condition. Under COBRA, a Member is entitled to Benefits if at the time of the qualifying event such Member is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences:

1. With respect to the Subscriber:
   a. the termination of employment (other than by reason of gross misconduct); or
   b. the reduction of hours of employment to less than the number of hours required for eligibility.

2. With respect to the dependent spouse or Dependent Domestic Partner* and dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be added as Dependents, provided the Contractholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):
   a. the death of the Subscriber; or
   b. the termination of the Subscriber’s employment (other than by reason of such Subscriber’s gross misconduct); or
   c. the reduction of the Subscriber’s hours of employment to less than the number of hours required for eligibility; or
   d. the divorce or legal separation of the dependent spouse from the Subscriber or termination of the domestic partnership; or
   e. the Subscriber’s entitlement to benefits under Title XVIII of the Social Security Act (“Medicare”); or
   f. a dependent child’s loss of dependent status under this Plan.

3. For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree’s dependent spouse and dependent children, when the employer files for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4. Such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1. With respect to COBRA enrollees

   The Member is responsible for notifying the Employer of divorce, legal separation, or a child’s loss of dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

   The Employer is responsible for notifying its COBRA administrator (or Plan administrator if the Employer does not have a COBRA administrator) of the Subscriber’s death, termination, or reduction of hours of employment, the Subscriber’s Medicare entitlement, or the Employer’s filing for reorganization under Title XI, United States Code.

   When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to
the Member by first class mail of his or her right to continue group coverage under this Plan.

The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member’s right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Member does not notify the COBRA administrator within 60 days, the Member’s coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA enrollees

The Member is responsible for notifying Blue Shield in writing of the Subscriber’s death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership or a child’s loss of dependent status under this Plan. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

The Employer is responsible for notifying Blue Shield in writing of the Subscriber’s termination or reduction of hours of employment within 30 days of the Qualifying Event.

When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under this Plan. The Member must then give Blue Shield notice in writing of the Member’s election of continuation coverage within 60 days of the later of (1) the date of the notice of the Member’s right to continue group coverage and (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

If the Member does not notify Blue Shield within 60 days, the Member’s coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

If this Plan replaces a previous group plan that was in effect with the Employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this Plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

Duration and Extension of Continuation of Group Coverage

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this Plan for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member’s continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the Qualifying Event has occurred which originally entitled the Member to continue group coverage under this Plan.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

Notification Requirements

The Employer or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact Blue Shield for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield at least 30 days before COBRA termination.

Payment of Dues

Dues for the Member continuing coverage shall be 102 percent of the applicable group dues rate if the Member is a COBRA enrollee or 110 percent of the applicable group dues rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be 150 percent of the applicable group dues rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, dues for Cal-COBRA coverage shall be 110 percent of the applicable group dues rate for months 30 through 36.

If the Member is enrolled in COBRA and is contributing to the cost of coverage, the employer shall be responsible for collecting and submitting all dues contributions to Blue
Shield in the manner and for the period established under this Plan.

Cal-COBRA enrollees must submit dues directly to Blue Shield of California. The initial dues must be paid within 45 days of the date the Member provided written notification to the Plan of the election to continue coverage and be sent to Blue Shield by first-class mail or other reliable means. The dues payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45 day period will disqualify the Member from continuation coverage.

**Effective Date of the Continuation of Coverage**

The continuation of coverage will begin on the date the Member’s coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as dues are timely paid.

**Termination of Continuation of Group Coverage**

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this Group Dental Service Contract (if the Employer continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer or to Blue Shield of California as applicable. Coverage will end as of the end of the period for which dues were paid;
3. the Member becomes covered under another group health plan that does not include a Pre-existing Condition exclusion or limitation provision that applies to the Member;
4. the Member becomes entitled to Medicare;
5. the Member no longer resides in Blue Shield’s Service Area;
6. the Member commits fraud or deception in the use of the Services of this Plan.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

**Continuation of Group Coverage for Members on Military Leave**

Continuation of group coverage is available for Members on military leave if the Member’s Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their Employer for information about their rights under the (USERRA). Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, Labor Code requirements for Medical Disability.

**X. Termination of Benefits and Cancellation Provisions**

Except as specifically provided under the Continuation of Group Coverage provision, if applicable, there is no right to receive Benefits of this dental Plan following termination of a Member’s coverage.

**Cancellation at Member Request**

The Member can cancel his or her coverage, including as a result of the Member obtaining other minimum essential coverage, with 14 days’ notice to Blue Shield. If coverage is terminated at a Member’s request, coverage will end at 11:59 p.m. Pacific Time on (a) the cancellation date specified by the Member if the Member gave 14 days’ notice; (b) 14 days after the cancellation is requested, if the Member gave less than 14 days’ notice; or (c) a date Blue Shield specifies if the Member gave less than 14 days’ notice and the member requested an earlier termination effective date. If the member is newly eligible for Medi-Cal, Children’s Health Insurance Program, or the Basic Health Plan (if a Basic Health Plan is operating in the service area of Covered California), the last day of coverage is the day before such coverage begins.

**Cancellation of Member’s Enrollment by Blue Shield**

Blue Shield may cancel a Member’s coverage in this Plan in the following circumstances:

1. The Member is no longer eligible for coverage in the Plan.
2. Non-payment of Premiums by the Employer for coverage of the Member.
3. Termination or decertification of this Blue Shield Plan.
4. The Subscriber changes from one dental plan to another during the annual Open Enrollment Period or during a Special Enrollment Period.

Blue Shield may cancel the Subscriber and any Dependent’s coverage for cause for the following conduct; cancellation is effective immediately upon giving written notice to the Subscriber and Employer:

1) Providing false or misleading material information on the enrollment application or otherwise to the Employer or Blue Shield; see the Cancellation/Rescission for Fraud, or Intentional Misrepresentations of Material Fact provision;

2) Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or

3) Obtaining or attempting to obtain Covered Services under the Group Dental Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

If the Employer does not meet the applicable eligibility, participation and contribution requirements of the Contract, Blue Shield will cancel this coverage after 30 days’ written notice to the Employer.

Any Premiums paid Blue Shield for a period extending beyond the cancellation date will be refunded to the Employer. The Employer will be responsible to Blue Shield for unpaid Premiums prior to the date of cancellation.

Blue Shield will honor all claims for Covered Services provided prior to the effective date of cancellation.

See the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact section.

Cancellation By The Employer

This dental Plan may be cancelled by the Employer at any time provided written notice is given to all Employees and Blue Shield to become effective upon receipt, or on a later date as may be specified by the notice.

Cancellation for Employer’s Non-Payment of Premiums

Blue Shield may cancel this dental Plan for non-payment of Premiums. If the Employer fails to pay the required Premiums when due, coverage will terminate upon expiration of the 30-day grace period following notice of termination for nonpayment of premium. The Employer will be liable for all Premium accrued while this coverage continues in force including those accrued during the grace period. Blue Shield will mail the Employer a Cancellation Notice (or Notice Confirming Termination of Coverage). The Employer must provide enrolled Employees with a copy of the Notice Confirming Termination of Coverage.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind the Contract for fraud or intentional misrepresentation of material fact by the Employer, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice to the Employer prior to any rescission.

In the event the contract is rescinded or cancelled, either by Blue Shield or the Employer, it is the Employer’s responsibility to notify each enrolled Employee of the rescission or cancellation. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

Date Coverage Ends

Coverage for a Subscriber and all of his or her Dependents ends at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Employer Group Dental Service Contract is discontinued; (2) the last day of the month in which the
Subscriber’s employment terminates, unless a different date has been agreed to between Blue Shield and the Employer; (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer (see Cancellation for Non-Payment of Premiums); or (4) the last day of the month in which the Subscriber and Dependents become ineligible for coverage, except as provided below.

Even if a Subscriber remains covered, his Dependents’ coverage may end if a Dependent become ineligible. A Dependent spouse becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber; coverage ends on the last day of the month in which the Dependent spouse became ineligible. A Dependent Domestic Partner becomes ineligible upon termination of the domestic partnership; coverage ends on the last day of the month in which the Domestic Partner becomes ineligible. A Dependent child who reaches age 26 becomes ineligible on the day before his or her 26th birthday, unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent.

In addition, if a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 60 days following that Dependent’s birth or placement for adoption, Benefits under this dental Plan for that child will end on the 31st day after the birth or placement for adoption at 11:59 p.m. Pacific Time.

If the Subscriber ceases work because of retirement, disability, leave of absence, temporary layoff, or termination, he or she should contact the Employer or Blue Shield for information on options for continued group coverage or individual options. If the Employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), a Subscriber’s payment of Premiums will keep coverage in force for such period of time as specified in such Act(s). The Employer is solely responsible for notifying their Employee of the availability and duration of family leaves.

Reinstatement

If the Subscriber had been making contributions toward coverage for the Subscriber and Dependents and voluntarily cancelled such coverage, he or she should contact Blue Shield or the Employer regarding reinstatement options. If reinstatement is not an option, the Subscriber may have a right to re-enroll if the Subscriber or Dependents qualify for a Special Enrollment Period (see Special Enrollment Periods in the Definitions section). The Subscriber or Dependents may also enroll during the annual Open Enrollment Period. Enrollment resulting from a Special Enrollment Period or annual Open Enrollment Period is not reinstatement and may result in a gap in coverage.

PLAN CHANGES

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

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

XI. MEMBER SERVICES AND GRIEVANCE PROCESS

MEMBER SERVICES

If you have a question about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may call your Dental Member Services Department at 800-286-7401.

Member Services can answer many questions over the telephone.

You may write to:

Dental Plan Administrator
Dental Member Services
425 Market St., 15th Floor
San Francisco, CA 94105.

Note: A DPA has established a procedure for our Members to request an expedited decision. A Member, Physician, or
representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. A DPA shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member’s condition not to exceed 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 Dental Member Services Department at the number listed above.

**Grievance Process**

Blue Shield of California has established a grievance procedure for receiving, resolving and tracking Members’ grievances.

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

The Member, a designated representative, or a provider on behalf of the Member, may also initiate a grievance by submitting a letter or a completed “Grievance Form”. The Member may request this Form from the Dental Member Services Department. If the Member wishes, the Dental Member Services 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 Member may also submit the grievance to the Dental Member Services Department online by visiting http://www.blueshieldca.com.

1-800-585-8111
Blue Shield of California
Dental Plan Administrator
PO Box 30569
Salt Lake City, UT 84130-0569

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 Members to file grievances for at least 180 days following any incident or action that is the subject of the Member’s dissatisfaction. See the previous Member Services section for information on the expedited decision process.

**XII. Other Provisions**

**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 800-286-7401 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 should cancel or refuse to renew the enrollment for you or your Dependents and you feel that such action was due to health or utilization of Benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

**Public Policy 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 Dental 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 is composed of Subscribers who are not employees, providers, sub-contractors or group contract brokers and who do not have financial interests in Blue Shield.
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  
Telephone: (415) 229-5065

Please follow the following procedure:

1. 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.

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

3. 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.

4. 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 10 business days after the minutes have been approved.

**GRACE PERIOD**

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

**CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION**

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Blue Shield will not disclose this information without your authorization, except as permitted by law.

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

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

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

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

**Toll-Free Telephone:**  
1-888-266-8080

**Email Address:**  
blueshieldca_privacy@blueshieldca.com

**ACCESS TO INFORMATION**

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

**NON-ASSIGNABILITY**

Benefits of this Plan are not assignable.

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

**RIGHT OF RECOVERY**

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member, or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in
excess of the benefits provided by the health plan, payment
of amounts that are the responsibility of the Subscriber or
Member (deductibles, copayments, coinsurance or similar
charges), payment of amounts that are the responsibility of
another payor, payment made after termination of the Sub-
scriber or Member’s eligibility, or payments on fraudulent
claims.

PLAN PROVIDER NETWORK
A contracted Dental Plan Administrator has established a
network of Dental Providers and other dental health pro-
fessionals in your Service Area.
The Dental Provider(s) you and your Dependents select
will provide telephone access 24 hours a day, seven days a
week so that you can obtain assistance and prior approval
of necessary Dental Care Services. The Directory of Den-
tal Providers in your Service Area indicates their location
and phone numbers.

INDEPENDENT CONTRACTORS
Plan Providers are neither agents nor employees of the
Plan but are independent contractors. In no instance shall
the Plan be liable for the negligence, wrongful acts, or
omissions of any person receiving or providing Services,
including any Dentist, Physician, Hospital, or other Pro-
vider or their employees.

XIII. DEFINITIONS
Terms used throughout this Evidence of Coverage are de-
fined as follows:

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

Allowed Amount – the amount a Plan Dentist agrees to
accept as payment from a contracted Dental Plan Adminis-
trator or the billed amount for non-Plan dentists.

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

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

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

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

Copayment – the amount that a Member is required to pay
for specific Covered Services.

Cosmetic Procedure – any surgery, service, appliance, or
supply designed to improve the appearance of an individu-
al by alteration of a physical characteristic which is within
the broad range of normal but which is considered unpleas-
ing or unsightly.

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

Dental Care Services – Necessary treatment on or to the
teeth or gums 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 Center – means a Dentist or a dental practice (with
one or more Dentists) which has contracted with a con-
tracted Dental Plan Administrator to provide dental care
Benefits to Members and to diagnose, provide, refer, su-
ervise, and coordinate the provision of all Benefits to
Members in accordance with this Contract.

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

Dental Necessity (Dentally Necessary) – Benefits are
provided only for Services that are Dentally Necessary as
defined in this Section.

1. Services which are of Dental Necessity include only
those which have been established as safe and effec-
tive and are furnished in accordance with generally
accepted national and California dental standards and
which are:
   a. Consistent with the symptoms or diagnosis of the
      condition; and
   b. Not furnished primarily for the convenience of the
      Member, the attending Dentist or other provide;
      and
   c. Furnished in a setting appropriate for delivery of
      the Service (e.g., a dentist’s office).

2. If there are two (2) or more Dentally Necessary Ser-
vices that can be provided for the condition, Blue
Shield will provide benefits based on the most cost-
effective Service.

Dental Plan Administrator (DPA) – Blue Shield of Cali-
ifornia has contracted with a contracted Dental Plan Ad-
ministrator (DPA). A DPA is a dental care service plan
licensed by the California Department of Managed Health
Care, which contracts with Blue Shield to administer de-
livery of dental services through a network of Plan Den-
tists and Dental Centers.
**Dentist** – a duly licensed Doctor of Dental Surgery or other practitioner who is legally entitled to practice dentistry in the state of California.

**Dependent** –

1. a Subscriber’s legally married spouse who is:
   a. not covered for Benefits as a Subscriber; and
   b. not legally separated from the Subscriber;
or,
2. a Subscriber’s Domestic Partner, who is not covered for Benefits as a Subscriber;
or,
3. a child of, adopted by, or in legal guardianship of the Subscriber, spouse or Domestic Partner, who is unmarried and is not in a domestic partnership. This category includes any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber and who is less than 19 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by the Plan as a dependent and has maintained membership in accordance with the contract.

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

**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.

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

**Elective Dental Procedure** – any dental procedures which are unnecessary to the dental health of the patient, as determined by a Plan Provider.

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

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

**Employee** – an individual who meets the eligibility requirements set forth in the Group Dental Service Contract between Blue Shield and the Employer.

**Employer (Contractholder)** – any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 1 employee and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

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

**Employer (Contractholder)** – any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 1 employee and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

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

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

**Family** – the Subscriber and all enrolled Dependents.
Group Dental Service Contract (Contract) – the Contract issued by Blue Shield to the Contractholder that establishes the Benefits which Members are entitled to receive from the Plan.

Member – either a Subscriber or Dependent.

Open Enrollment Period — that period of time set forth in the Contract during which eligible Employees and their Dependents may enroll in this coverage, or transfer from another dental benefit plan sponsored by the Employer to this coverage.

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

Orthodontics – Dental Care Services specifically related to necessary Services for the treatment for malocclusion and the proper alignment of teeth.

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

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

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

Physician – an individual licensed and authorized to engage in the practice of medicine (M.D.) or osteopathy (D.O.).

Plan – the Blue Shield Dental Plan.

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

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

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.

Service Area – that geographic area served by the Plan.

SHOP – the Small Business Health Option Program (“SHOP”) operated by Covered California through which an Eligible Employer can provide its employees and their Dependents with access to one or more dental plans.

Special Enrollment Period – a period during which an individual who experiences certain qualifying events may enroll in, or change enrollment in, this dental plan outside of the initial and annual Open Enrollment Periods. An eligible Employee or an Employee’s Dependent has a 60-day Special Enrollment Period if any of the following occurs:

1) An Employee or Dependent loses minimum essential coverage for a reason other than failure to pay Premiums on a timely basis.

2) An Employee or Dependent has lost or will lose coverage under another employer dental benefit plan as a result of (a) termination of his or her employment; (b) termination of employment of the individual through whom he or she was covered as a Dependent; (c) change in his or her employment status or of the individual through whom he or she was covered as a Dependent, (d) termination of the other plan’s coverage, (e) exhaustion of COBRA or Cal-COBRA continuation coverage, (f) cessation of an Employer’s contribution toward his or her coverage, (g) death of the individual through whom he or she was covered as a Dependent, or (h) legal separation, divorce or termination of a Domestic Partnership.

3) A Dependent is mandated to be covered as a Dependent pursuant to a valid state or federal court order. The dental benefit plan shall enroll such a Dependent child within 60 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.

4) An Employee or Dependent who was eligible for coverage under the Healthy Families Program or Medi-Cal has lost coverage as a result of the loss of such eligibility.

5) An Employee or Dependent who becomes eligible for the Healthy Families Program or the Medi-Cal premium assistance program and requests enrollment within 60 days of the notice of eligibility for these premium assistance programs.

6) An Employee who declined coverage, or an Employee enrolled in this plan, subsequently acquires Dependents through marriage, establishment of Domestic Partnership, birth, adoption or placement for adoption.

7) An Employee’s or Dependent’s enrollment or non-enrollment in a dental plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the SHOP, Covered California, HHS, or any of their instrumentalities as evaluated and determined.
by Covered California. In such cases, Covered California may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

8) An Employee or Dependent adequately demonstrates to Covered California that the dental plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the Employee or Dependent.

9) An Employee or Dependent gains access to new dental plans as a result of a permanent move.

10) An Employee or Dependent demonstrates Covered California, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as Covered California may provide.

11) An Employee or Dependent has been released from incarceration.

12) An Employee or Dependent was receiving services from a contracting provider under another dental benefit plan, as defined in Section 1399.845 of the Health & Safety Code or Section 10965 of the Insurance Code, for one of the conditions described in California Health & Safety Code Section 1373.96(c) and that provider is no longer participating in the dental benefit plan.

13) An Employee or Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

14) An Employee or Dependent is a member of an Indian tribe which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, as described in Title 25 of the United States Code Section 1603.

15) An Employee or Dependent qualifies for continuation coverage as a result of a qualifying event, as described in the Group Continuation Coverage section of this Evidence of Coverage.

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

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

**Treatment in Progress** – Partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken. Ongoing orthodontic cases are not considered Treatment in Progress under this definition.
NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Spanish

免费语言服务。您可获得口译员服务，可以读文件给您听，有些文件有中文的版本，也可以把这些文件寄给您。欲取得协助，请致电您的保险卡所列的电话号码，或拨打1-866-346-7198与我们联络。Chinese

Các Dịch Vụ Tự Giám Ng-non Miền Phú. Quy vĩ có thể được dịch vụ thông dịch. Quy vĩ có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tài số điện thoại ghi trên thẻ hội viên của quý vĩ hoặc 1-866-346-7198. Vietnamese


Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipapalabas mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, layawan kami sa numerong nakaisa sa iyong ID card o sa 1-866-346-7198. Tagalog

Ալիքային Պահպանչում ծառայություններ. Անձնական մասին երիտասարդերի կազմակերպությունը հանձնում է մանուշական ծառայություն և բարոյական ծառայություն այդ հանձնաժողովի գծով. Օգնություն գտնելու առաջարկում են հանձնաժողովի 1-866-346-7198 համարով. Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、カード記載の番号または1-866-346-7198までお問い合わせください。 Japanese

کمک، با ما از طریق شماره تلفنی که روی کارت مشناسی شما به شما فراهم می‌شود، که 1-866-346-7198 می‌توانید با ما در ارتباط داشته باشید. Persian

穆کادس مترجم بیدار باید بالاتر می‌باشد. در مورد این محرک که مترجم شما است، و دوباره مدارک به زبان فارسی برای شما نمایان می‌شود. طایف دیوانه

مکتوب مترجم از این محرک که مترجم شما است، و دوباره مدارک به زبان فارسی برای شما نمایان می‌شود. طایف دیوانه

کمک، با ما از طریق شماره تلفنی که روی کارت مشناسی شما به شما فراهم می‌شود، که 1-866-346-7198 می‌توانید با ما در ارتباط داشته باشید. Persian

заказанный переводчик или переводчик, который привезет вам документы, в том числе перевод на русский язык. Если вам нужна помощь, звоните по номеру, указанному на вашем идентификационном карте, или 1-866-346-7198. Russian

سیستم ترجمه به دست تخفیف. می‌توانید از خدمات یک مترجم رایگان استفاده کنید و دوباره مدارک به زبان فارسی برای شما نمایان می‌شود. طایف دیوانه

کمک، با ما از طریق شماره تلفنی که روی کارت مشناسی شما به شما فراهم می‌شود، که 1-866-346-7198 می‌توانید با ما در ارتباط داشته باشید. Persian

خدمات ترجمه بدون تخفیفات. يمكننا الحصول على مترجم وقراءعة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بالرقم 1-866-346-7198. Arabic

Cov Key Pab Tkhats Lus Tsis Them Nqî. Koj yauv thov tau kom muag neeg los tkhats lus rau koi thab kom neeg nyeem ov niaw va lus Eimoob. Yog xav tau kev pab, hr rau peb ntawm bus xov tooj nyob hauv koi dam yuaj ID los sis 1-866-346-7198. Hmong
Customer Service
1-800-286-7401

The hearing impaired may call Blue Shield’s Member Services Department through Blue Shield’s toll-free TTY number at 1-800-241-1823.

Please direct correspondence to:

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

Please send claims for all Covered California services to:

Blue Shield of California
Covered California Claims
P. O. Box 400
Chico, CA95927