Blue Shield Dental PPO Plan for Medicare Supplement Plan Subscribers

Disclosure Form

Effective April 1, 2024

Notice

This Disclosure Form is only a summary of the Dental PPO Plan. The *Evidence of Coverage and Health Service Agreement* (EOC) should be consulted to determine governing contractual provisions.

The EOC booklet contains the terms and conditions of coverage of the Blue Shield Dental PPO Plan. It is your right to view the EOC prior to enrollment in the Dental PPO Plan. After you enroll, you will automatically receive an EOC booklet.

Please read this Disclosure Form and the EOC carefully and completely so that you understand which services are covered and the limitations and exclusions that apply to the Dental PPO Plan. If you have special healthcare needs, you should read carefully those sections that apply to you. A Dental PPO Matrix summarizing key elements of the Dental PPO Plan is attached to this Disclosure Form.

To obtain a copy of the EOC, or if you have questions about the benefits of the Dental PPO Plan, please contact the Dental Customer Service Department at (888) 679-8928 or TTY 711.

Table of Contents

Introduction to the Blue Shield of California Dental PPO Plan for Medicare Supplement Plan Subscribers

This Plan is an individual dental PPO plan made available for Medicare Supplement Plan Subscribers. This is not a Medicare Supplement Plan. Note: You must be currently enrolled in Medicare Parts A and B to be eligible to apply.

If you have questions about your Benefits, contact Blue Shield's Dental Customer Service before dental services are received.

Blue Shield of California's dental plans are designed to reduce the cost of dental care to you, the Subscriber. In order to reduce your costs, much greater responsibility is placed on you for managing the Benefits provided under the dental plans.

Blue Shield of California's dental plans are administered by a Dental Plan Administrator. A Dental Plan Administrator is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to underwrite and administer the delivery of dental services through a network of Participating Dentists.

Before Obtaining Dental Services

You are responsible for assuring that the Dentist you choose is a Participating Dentist.

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

Note: The Dental Plan Administrator will respond to all requests for precertification and prior authorization within five business days from receipt of the request. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain, the Dental Plan Administrator will respond as soon as possible to accommodate the Subscriber's condition, not to exceed 72 hours from receipt of the request.

Failure to meet these responsibilities will not necessarily result in the denial of Benefits. However, by following the precertification process, both you and your Dentist will know in advance which services are covered and the Benefits that are payable.

Principal benefits and coverages

The services covered, and the amount you pay, depend on the provider you choose when you need dental care. Please refer to the Dental PPO Matrix that is attached to and is part of this Disclosure Form. Also, refer to the EOC, which you will receive after you enroll. These documents offer more detailed information on the Benefits and coverage included in your Dental PPO Plan (Plan).

Principal exclusions and limitations on benefits

General Limitations

The following services will be subject to limitations as set forth below:

1. One (1) in a four (4) month period:
   a. Routine prophylaxis.
2. One (1) in a six (6) month period:
   a. Periodic oral exam;
   b. Bitewing x-rays (maximum four (4) per year):
   c. Recementations if the crown or inlay was provided by other than the original dentist; not eligible if the dentist is doing the recementation of a service he/she provided within twelve (12) months;
3. One (1) in twelve (12) month period:
   a. Denture (complete or partial) reline;
   b. Oral cancer screening.
4. One in twenty-four (24) months:
   a. Full mouth debridement;
   b. Scaling and root planning per area;
   c. Occlusal guards;
   d. Diagnostic casts.
5. One in thirty-six (36) months:
   a. Mucogingival surgery per area;
   b. Osseous surgery per quad;
   c. Gingival flap per quad;
   d. Gingivectomy per quad;
   e. Gingivectomy per tooth;
   f. Bone replacement grafts for periodontal purposes;
   g. Guided tissue regeneration for periodontal purposes.
6. One (1) in a five (5) year period:
   a. Full mouth series and panoramic x-rays;
   b. Single crowns and onlays;
   c. Single post and core buildups;
   d. Crown buildup including pins;
   e. Prefabricated post and core;
   f. Cast post and core in addition to crown;
   g. Complete dentures;
   h. Partial dentures;
   i. Fixed partial denture (bridge) pontics;
   j. Fixed partial denture (bridge) abutments;
   k. Abutment post and core buildups;
   l. Diagnostic cast.
7. Oral surgery services are limited to removal of teeth, bony protuberances and frenectomy.
8. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the

dentist. For example, an alternate of a partial denture will he applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.

9. General or IV Sedation is covered for:
    a. 3 or more surgical extractions;
    b. 1 or more impactions;
    c. Full mouth or arch alveoloplasty;
    d. Surgical root recovery from sinus;
    e. Medical problem contraindicates the use of local anesthesia.

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

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

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

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

General exclusions

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

1. Charges for services in connection with any treatment to the gums for tumors, cysts, and neoplasms;
2. Charges for implants or the removal of implants (surgically or otherwise) and any appliances and/or crown attached to implants unless your Plan provides implant Benefits;
3. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if the Dental Plan Administrator or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by the Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;
4. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums, and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint;
5. Congenital mouth malformations or skeletal imbalances, including treatment required as the result of Orthognathic surgery, orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
6. All prescription and non-prescription drugs;
7. Charges for services performed by a close relative or by a person who ordinarily

resides in the Subscriber's home;

8. Services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature, or which do not have uniform professional endorsement;
9. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;
10. Procedures which are principally cosmetic in nature, such as bleaching, veneers, and personalization or characterization of dentures;
11. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, onlay, etc.) within five (5 years) of it's installation;
12. Myofunctional therapy; biofeedback procedures; athletic mouth guards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures; sealants;
13. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;
14. Charges for services in connection with orthodontia;
15. Alloplastic bone grafting materials;
16. Bone grafting done for socket preservation after tooth extraction or in preparation for implants;
17. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
18. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
19. Dental services performed in a hospital or any related hospital fee;
20. Any service, procedure, or supply for which the prognosis for long-term success is not reasonably favorable as determined by the Dental Plan Administrator and its dental consultants;
21. For which the Subscriber is not legally obligated to pay, or for Covered Services for which no charge is made to the Subscriber;
22. Treatment as a result of accidental injury including setting of fractures or dislocation;
23. Treatment for which payment is made by any governmental agency, including any foreign government;
24. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
25. Charges for onlays or crowns installed as multiple abutments;
26. Charges for dental appointments which are not kept;
27. Charges for services incident to any intentionally self-inflicted injury;
28. General anesthesia including intravenous and inhalation sedation, except when of Dental Necessity;

    General anesthesia is considered dentally necessary when its use is:

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

    Patient apprehension or patient anxiety will not constitute Dental Necessity.

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

29. Removal of 3rd molar (wisdom) teeth other than for Dental Necessity. Dental Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not dental necessity;
30. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;
31. Any service, procedure, or supply which is received or started prior to the Subscriber's Effective Date of coverage. For the purpose of this Limitation, the date on which a procedure shall be considered to have started is defined as follows:
    a. For full dentures or partial dentures: on the date the final impression is taken;
    b. For fixed bridges, crowns, onlays: On the date the teeth are first prepared;
    c. For root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex;
    d. For periodontal surgery: on the date the surgery is actually performed;
    e. For all other services: on the date the service is performed.
32. 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.

Prepayment fees

Monthly Dues for this Plan are attached to this Disclosure Form.

Initial Dues are payable on the Effective Date of this Plan, and subsequent Dues are payable on the same date of each succeeding month. All Dues must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this Plan up to the date immediately before the next date due, but not after.

Other charges

Deductibles, Copayments, and Benefit Maximums

Certain Benefits of this Plan require the application of deductibles, Copayments, and charges in excess of benefit maximums and/or may be subject to maximum payments. Please refer to the Dental PPO Matrix, which is attached to this Disclosure Form, to find information regarding the Dues for the Plan, the various deductibles, and benefit maximums that are applicable to the Plan.

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

Choice of dental providers

With Blue Shield of California's dental plans, you receive greater Benefits when using Dental Providers.

Dental Providers agree to accept the Dental Plan Administrator's payment, plus your payment of any applicable deductible and Copayment, as payment in full for Covered Services. This is not true of non-participating Dentists.

In some instances, the non-participating Dentist's Allowable Amount may be higher than the Allowable Amount for a Dental Provider; however, if you go to a non-participating Dentist, your reimbursement for a service by that non-participating Dentist may be less than the amount billed. The Subscriber is responsible for all differences between the amount you are reimbursed and the amount billed by non-participating Dentists. It is therefore to your advantage to obtain dental

services from participating Dental Providers.

Dental Providers submit claims for payment after their services have been rendered. These payments go directly to the Dental Provider. You or your non-participating Dentist also submits claims for payment after services have been rendered. If you receive services from non-participating Dentists, you have the option of having payments sent directly to the non-participating Dentist or sent directly to you. The Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

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

A list of Dental Providers located in your area can be obtained by contacting the Dental Plan Administrator at (888) 702-4171. You may also access a list of Dental Providers through Blue Shield's Internet site located at blueshieldca.com.

Liability of Subscriber or enrollee for payment

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

Continuity of care by a terminated provider

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

Financial responsibility for continuity of care services

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

Reimbursement provisions

Procedure for filing a claim

Claims for Covered Services should be submitted on a dental claim form which may be obtained from the Dental Plan Administrator or Blue Shield of California. Have your Dentist complete the form and mail it to the Dental Plan Administrator service center shown on the last page of this booklet.

The Dental Plan Administrator will provide payments in accordance with the provisions of the EOC and Health Services Agreement. You will receive an Explanation of Benefits after the claim has been processed.

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

Utilization review

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

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

Safety Code.

To request a copy of the document describing this utilization review process, call the Member Service Department at (800) 585-8111.

Facilities

Directories of Dental Providers are available on our Web site **blueshieldca.com** or by calling (888) 702-4171.

Renewal provisions

Blue Shield of California will offer to renew the agreement except in the following instances:

1. Non-payment of Dues;
2. Fraud, misrepresentation, or omission of information on the application;
3. Termination of Plan type by Blue Shield of California;
4. Termination of the Subscriber's Medicare Parts A and B coverage.

Termination of Benefits

Cancellation/reinstatement of the agreement

1. Blue Shield of California may terminate your EOC and Health Services Agreement together with all like agreements by giving 90 days' written notice. No Subscriber shall be terminated individually by Blue Shield of California for any cause other than as provided under this section. A Subscriber desiring to terminate his or her EOC and Health Services Agreement shall give Blue Shield of California 30 days' notice.

The EOC and Health Services Agreement may be cancelled by Blue Shield of California for false representations to, or concealment of, material facts from Blue Shield of California in any health statement, application, or any written instruction furnished to Blue Shield of California by the Subscriber at any time before or after issuance of the EOC and Health Services Agreement, or fraud or deception in enrollment. The EOC and Health Services Agreement may also be cancelled if the Subscriber fails or refuses to provide access to documents and other information that was provided in the application for coverage.

Cancellation in such instances shall be effective as of the original Effective Date of coverage, without prior notice to the Subscriber.

Blue Shield of California may terminate the EOC and Health Services Agreement for cause immediately upon written notice for the following:

a. Material information that is false or misrepresented information provided on the enrollment application or given to Blue Shield of California;

b. Permitting use of your Blue Shield of California ID card by someone other than yourself to obtain services;

c. Obtaining or attempting to obtain services under the EOC and Health Services Agreement by means of false, materially misleading, or fraudulent information, acts, or omissions;

d. Abusive or disruptive behavior which (1) threatens the life or well-being of Blue Shield of California personnel and providers of services; or (2) substantially impairs the ability of

   Blue Shield of California to arrange for services to the Subscriber; or (3) substantially impairs the ability of providers of service to furnish services to the Subscriber or to other patients.

e. Blue Shield of California may terminate this Agreement for cause upon thirty (30) days' written notice if the Subscriber moves out of California.

Blue Shield of California shall, within 30 days of the notice of termination or cancellation, return to the Subscriber the amount of prepaid Dues, if any, minus any monies paid by Blue Shield of California for incurred claims

that Blue Shield of California determines will not have been earned as of such terminating date. However, Blue Shield of California reserves the right to recoup all payments from the Subscriber for incurred charges, which exceed the Dues, paid by the Subscriber, if the EOC and Health Services Agreement is cancelled for fraud or deception.

2. Cancellation of the EOC and Health Services Agreement for nonpayment of Dues.

If the EOC and Health Services Agreement is being cancelled because of failure to pay the required Dues when due, the Plan will send a Notice of Start of Grace Period and will terminate the day following the 30-day grace period. You will be liable for all Dues accrued while this Agreement continues in force including those accrued during this 30-day grace period.

Within five (5) business days of canceling or not renewing the EOC and Health Services Agreement, Blue Shield of California will mail a Notice of End of Coverage, which will provide the following:

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

b. The specific date and time when coverage ended;

c. Information regarding the availability of reinstatement of coverage under the EOC and Health Services Agreement.

3. Cancellation for any reason of a Blue Shield dental plan (by yourself or Blue Shield), requires a wait period of 12 months from the date of cancellation before a Subscriber can reapply.

4. Termination by Blue Shield of California if Subscriber is No Longer Enrolled in Medicare:

   This Agreement shall terminate on the date the Subscriber is no longer enrolled under Parts A and B or Medicare. Blue Shield of California shall refund the prepaid dues, if any, that Blue Shield of California determines will not have been earned as of the termination date. Blue Shield of California reserves the right to subtract from any such dues refund any amounts paid by Blue Shield of California for benefits paid or payable by Blue Shield of California prior to the termination date.

Grievance process

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

Ratio of dental services

The minimum target loss ratio of premium costs to dental services excluding copayments, deductibles, and any member expenses is estimated to be 60%. This ratio was calculated after provider discounts were applied.

External independent medical review

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

Department of Managed Health Care review

The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a grievance against your health Plan, you

should first telephone your health Plan at the Customer Service number in your EOC, and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)**. The Department's internet website, **(www.dmhc.ca.gov)**, has complaint forms, IMR application forms, and instructions online.

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

Confidentiality of personal and health information

Blue Shield is committed to protecting your personal and health information in each of the settings in which such information is received or exchanged.

When you complete an application for coverage, your signature authorizes Blue Shield to collect personal and health information that includes both your medical information and individually identifiable information about you, such as your address, telephone number, or other individual information. If you become a Blue Shield subscriber, this general consent allows Blue Shield to communicate with your physicians and other providers regarding treatment and payment decisions.

Blue Shield also participates in quality measurement activities that may require us to access your personal and health information. We have policies to protect this information from inappropriate disclosure, and we release this information only if aggregated or encoded. We will not disclose, sell, or otherwise use your personal and health information unless permitted by law and to the extent necessary to administer the health Plan. We will obtain written authorization from you to use your personal and health information for any other purpose. For any of our prospective or current members unable to give consent, we have a policy in place to protect your rights, and that permits your legally authorized representative to give consent on your, behalf. Blue Shield also will not release your personal and health information to your employer without your specific authorization, unless such release is permitted by law.

Through its contracts with providers, Blue Shield has policies in place to allow you to inspect your medical records maintained by your provider and, when needed, to include a written statement from you. You also have the right to review personal and health information that may be maintained by Blue Shield.

If you are a prospective, current, or former member and need more detailed information about Blue Shield's Corporate Confidentiality policy, it is available on Blue Shield's Web site at **blueshieldca.com** or by calling Customer Service.

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.

Access to Information

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

Definitions

Allowable Amount – The Dental Plan Administrator Allowance (as defined below) for the Covered Service (or Covered Services) rendered, or the provider's billed charge, whichever is less. The Dental Plan Administrator Allowance is:

1. The amount the Dental Plan Administrator has determined is an appropriate payment for the Covered Service(s) rendered in the provider's geographic area, based upon such factors as the Dental Plan Administrator's evaluation of the value of the Covered Service(s) relative to the value of other Covered Services, market considerations, and provider charge patterns; or
2. Such other amount as the Participating Dentist and the Dental Plan Administrator have agreed will be accepted as payment for the Covered Service(s) rendered; or
3. If an amount is not determined as described in either 1 or 2 above, the amount the Dental Plan Administrator determines is appropriate considering the particular circumstances and the Covered Services rendered.

Benefits (Covered Services) – Those services which a Subscriber is entitled to receive pursuant to the terms of the EOC and Health Services Agreement.

Copayment – The fixed dollar amount or a percentage of charges that the Subscriber pays. The Copayment and deductible are the Subscriber's share of the costs of Covered Services.

Covered Services (Benefits) – Those services which a Subscriber is entitled to receive pursuant to the terms of the EOC and Health Services Agreement.

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

Dental Plan Administrator (DPA) – Blue Shield of California has contracted with the Plan's Dental Plan Administrators. A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to underwrite and administer delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from non-participating Dentists.

Dental Provider – A Doctor of Dental Surgery who has signed a service contract with the Dental Plan Administrator to provide dental services to Subscribers.

Dentist – A duly licensed doctor of dental surgery or other practitioner who is legally entitled to practice dentistry in the state of California.

Disclosure Form – The Disclosure Form is a summary of the Dental PPO Plan.

Dues – The monthly pre-payment that is made to Blue Shield of California on behalf of each Subscriber.

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

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.

Limitation – Means any provision other than an exception or a reduction, which restricts coverage under the Plan.

Participating Dentist – A Doctor of dental surgery who has signed a service contract with the Dental Plan Administrator to provide dental services to Subscribers.

Plan – The Blue Shield of California Dental PPO Plan.

Subscriber – An individual who satisfies the eligibility requirements of the agreement, and who is enrolled and accepted by Blue Shield of California as a Subscriber, and has maintained Plan membership in accord with the EOC and Services Agreement.

Dental PPO Matrix

This matrix is a summary only. The *Disclosure* and *Plan Contract* should be consulted for a detailed description of coverage Benefits and limitations.

THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

	Dental PPO 1000		Dental PPO 1500	
	Participating Dentist	**Non-Participating Dentist**	**Participating Dentist**	**Non-Participating Dentist**
Deductible	$75/person		$50/person	
Calendar-year maximum	$1,000 ($750 may be used for Non-Participating Dentists)		$1,500 ($1,000 may be used for Non-Participating Dentists)	
Diagnostic and preventive care[1] (not subject to plan deductibles with network dentists; includes routine oral exams, X-rays, and cleanings)	100%	50%	100%	80%
Basic Services[1] (includes services such as anesthesia, emergency treatment to relieve pain, restorative dentistry, sealants, and space maintainers)	50%	50%	80%	70%
Major Services[1,2] 12-month waiting period for DPPO 1500 and a 6-month waiting period for DPPO 1000 (All plans include services such as crown buildups, crowns, prosthetics, onlays, jackets, posts and cores, and veneers. DPPO 1500 also includes implants.)	50%	50%	50%	50%

1 The coinsurance percentage indicated is a percentage of allowed amounts that we pay to providers. Non-network providers can charge more than our Allowable Amount. When members use non-network providers, they must pay the applicable Copayment/coinsurance plus any amount that exceeds our Allowable Amount. Charges in excess of the Allowable Amount do not count toward the calendar- year deductible or copayment maximum.

2 Dental PPO 1500 members have a 12-month waiting period and Dental PPO 1000 members have a 6-month waiting period for major restorative services and procedures (such as crowns), and removable fixed prosthetics. The waiting period may be waived with proof of prior comprehensive coverage.

Claims submission information

For pre-admission review and for claims submission and information contact Blue Shield of California.

By phone, call Dental Customer Services at **(888) 679-8928**

By mail, please direct correspondence to:
Blue Shield of California
P.O. Box 272590
Chico, CA 95927-2590