

Pediatric Dental PPO Plan

Evidence of Coverage

Group

An independent member of the Blue Shield Association

Evidence of Coverage

Blue Shield of California Pediatric Dental PPO Plan

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 in the dental Plan.

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 Dental Plan you are being offered. This is to assist you in comparing group dental plans available to you.

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Blue Shield Customer Service at the address or telephone number listed at the back of this booklet.

This booklet constitutes only a summary of the Dental Care Plan. The group Plan contract must be consulted to determine the exact terms and conditions of coverage.

The group contract is on file with your employer and a copy will be furnished upon request.

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

Please read this Evidence of Coverage booklet carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your dental coverage.

Should you have any questions regarding your Blue Shield of California Dental Plan, see your employer or contact any of the Blue Shield of California offices listed on the last page of this booklet.

IMPORTANT

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

Benefits of the 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 the 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 the 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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INTRODUCTION TO THE BLUE SHIELD OF CALIFORNIA PEDIATRIC DENTAL PPO PLAN

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 contracted Dental Plan Administrator (DPA) which is a dental care service plan licensed by the California Department of Managed Health Care, and 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 a contracted Dental Plan Administrator at 1-800-286-7401. You may also access a list of Participating Dentists through Blue Shield's Internet site located at <http://www.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: A contracted Dental Plan Administrator will respond to all requests for precertification and prior authorization within 5 business days from receipt of the request. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a contracted Dental Plan Administrator will respond as soon as possible to accommodate the Member'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.

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

PARTICIPATING DENTISTS

With Blue Shield of California's dental plans, you receive a greater Benefit when using Participating Dentists.

Participating Dentists agree to accept a contracted Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Copayment, as payment in full for covered Services. This is not true of Non-Participating Dentists.

In some instances, the Non-Participating Dentist's Allowable Amount may be higher than the Allowable Amount for a Participating Dentist; 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 Dentists.

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

Blue Shield contracts with Hospitals and Physicians to provide Services to Members for specified rates. This contractual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the contract. If you want to know more about this payment system, contact Customer Service at the number provided on the back page of this booklet.

A list of Participating Dentists located in your area can be obtained by contacting a contracted Dental Plan Administrator at 1-800-286-7401. You may also access a list of Participating Dentists through Blue Shield's Internet site located at <http://www.blueshieldca.com>.

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

ELIGIBILITY AND ENROLLMENT

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, in-

cluding 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 applications 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.

DEDUCTIBLE

CALENDAR YEAR DEDUCTIBLE

For Plans with a Calendar Year Deductible, the Deductible applies to all covered Services and supplies furnished by Participating and Non-Participating Dentists, except as specified in the Summary of Benefits which is attached to and made a part of this Evidence of Coverage. It is the amount which you must pay out of pocket for charges that would otherwise be payable for dental care Services and supplies. Charges in excess of the Allowable Amount do not apply toward the Deductible. This per Member Deductible applies separately to each covered Member, except that no more than the Family Deductible amount is required of a Family in a Calendar Year. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan.

The Calendar Year per Member is listed in the Summary of Benefits which is attached to and made a part of this EOC.

PRECERTIFICATION OF DENTAL BENEFITS PROGRAM

Before any course of treatment expected to cost more than \$250 is started, you should obtain Precertification of Benefits. Note: If your Plan provides Special Implant Benefits, you must obtain Precertification/prior authorization for these Benefits before Services are provided or Benefits will be denied.

Your Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic X-rays to a contracted Dental Plan Administrator. A contracted Dental Plan Administrator will review the dental treatment plan to determine the benefits payable under the Plan. The benefit determination for the proposed treatment plan will then be promptly returned to the Dentist. When the treatment is completed, your claim form should be submitted to a contracted Dental Plan Administrator for payment determination. A contracted Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

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

If your Plan provides Special Implant Benefits, failure to obtain Precertification/prior authorization of these Benefits will result in a denial of Benefits. For all other Benefits, failure to obtain Precertification of Benefits will not necessarily result in a denial of Benefits. If the Precertification process is not followed, a contracted Dental Plan Administrator will still determine payment by taking into account alternative procedures, Services or materials for the dental condition based on professionally recognized standards of dental practice. However, by following the Precertification process both you and your Dentist will know in advance which services are covered and the Benefits that are payable.

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

Example:

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

PAYMENT

PAYMENT AND SUBSCRIBER COPAYMENT RESPONSIBILITIES

After any applicable Deductible has been satisfied, payments will be provided based on the Allowable Amount determined by a contracted Dental Plan Administrator, to Participating and Non-Participating Dentists for the Benefits of this Plan, subject to the Copayment percentages and Benefit maximums indicated below.

The maximum per Member, per Calendar Year amount payable by Blue Shield for covered Services and supplies provided by any combination of Participating and Non-Participating Dentists is listed in the Summary of Benefits which is attached to and made a part of this EOC.**

**NOTE: If your Plan provides benefits for Orthodontia, a separate Calendar Year Benefit maximum applies to Ortho-

dontic Services. See the Summary of Benefits which is attached to and made a part of this EOC.

PARTICIPATING DENTISTS

Services rendered by Participating Dentists are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount.

When a Benefit of the Plan, Services rendered for Orthodontic Services are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount as well as all charges for Services in excess of the Benefit maximum.

NON-PARTICIPATING DENTISTS

Services rendered by Non-Participating Dentists are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount, as well as any charges above the Allowable Amount.

When a Benefit of the Plan, Services rendered for Orthodontic Services are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits under Blue Shield's Payment Percentage section. Subscribers are responsible for the remaining percentage amount. Subscribers are also responsible for any charges above the Allowable Amount, as well as all charges for Services in excess of the Benefit maximum.

Payment by a contracted Dental Plan Administrator or Blue Shield of California for covered Services will be made on the basis of the Allowable Amount as determined by Blue Shield of California.

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

Payment by Blue Shield of California for Services rendered by a Non-Participating Dentist, plus your payment of the applicable Deductible and Copayment amount, may or may not be accepted by a Non-Participating Dentist as payment in full. Therefore, you may have to pay an amount in addition to the Copayment. Blue Shield of California suggests that you discuss this beforehand with your Dentist if he is not a Participating Dentist. Any difference between the Blue Shield of California payment and the Non-Participating Dentist's charges are your responsibility.

If the covered Member recovers from a third party the reasonable value of covered Services rendered by a Participating Dentist, the Participating Dentist who rendered these Services is not required to accept the fees paid by a contracted Dental Plan Administrator as payment in full, but may collect from the covered Member the difference, if

any, between the fees paid by a contracted Dental Plan Administrator and the amount collected by the covered Member for these Services.

Calendar Year Maximum Payment

The calendar year maximum for covered Services and Supplies provided by Participating Dentists and Non-Participating Dentists is specified on the Summary of Benefits.

Out-Of-Pocket Maximum

The out-of-pocket maximum per Member for all Covered Services and supplies furnished by Participating and Non-Participating Dentists 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.

PRINCIPAL BENEFITS AND COVERAGES

The Benefits of 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. Blue Shield payments for these Services, if applicable, are also listed in the Summary of Benefits.

IMPORTANT INFORMATION

Services are Benefits of the Plan when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit descriptions below, and to the Limitations and Exclusions listed in this booklet.

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

Payments are based on the Allowable Amount as defined, and are subject to the dental Benefit deductible, the indicated Copayment percentages, and all Benefit maximums as specified in the Summary of Benefits.

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.

LIMITATIONS AND EXCLUSIONS

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.
 - a. 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:

- i. 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.
 - ii. 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.
 - iii. 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.
 - iv. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
- b. Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:
- i. 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.
 - ii. 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.

- iii. 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.
 - iv. Fixed bridges are optional when provided in connection with a partial denture on the same arch.
 - v. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
9. Removable Prosthetics.
- 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 per denture.
- d. Implants are considered an optional service.
- e. Stayplates are a Covered Service only when used as anterior space maintainers for children.

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 Allowable 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 Allowable 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 government 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 Allowable Amount).

Contact the Customer Service department at the telephone number shown at the end of this document 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 Participating Dentist may seek reimbursement from other third party payors for the balance of its reasonable charges for Services rendered under the Plan.

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 paid by Blue Shield or a contracted Dental Plan Administrator on a fee-for-service basis 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 covered 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 covered 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 with 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.

TERMINATION OF BENEFITS (CANCELLATION AND RESCISSION OF COVERAGE)

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.

LIABILITY OF SUBSCRIBERS IN THE EVENT OF NONPAYMENT BY BLUE SHIELD OF CALIFORNIA

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

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

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

PREPAYMENT FEE (DUES OR PREMIUMS)

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 (1) 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.

PLAN CHANGES

The Benefits of this Plan, including but not limited to Covered Services, Deductible, and Co-payment, 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.

BLUE SHIELD ONLINE

Blue Shield's Internet site is located at <http://www.blueshieldca.com>. Members with Internet access and a Web browser may view and download healthcare information.

CHOICE OF PROVIDERS

Under the Blue Shield of California Dental PPO plans, you have a free choice of any licensed Dentist including such providers outside of California.

FACILITIES (PARTICIPATING PROVIDERS)

The names of Participating Dentists in your area may be obtained by contacting a contracted Dental Plan Administrator at 1-800-286-7401. You may also access a list of Participating Dentists through Blue Shield's Internet site located at <http://www.blueshieldca.com>.

CUSTOMER SERVICE

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

1-800-286-7401
Dental Plan Administrator
Dental Customer Service
425 Market Street, 15th Floor
San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

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

Note: A DPA has established a procedure for our Subscribers to request an expedited decision. A Subscriber, Physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber,

or when the Subscriber is experiencing severe pain. A DPA shall make a decision and notify the Subscriber 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 the Dental Customer Service Department at the number listed above.

GRIEVANCE PROCESS

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

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

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

1-800-286-7401

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

DEPARTMENT OF MANAGED HEALTH CARE REVIEW

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at 1-800-286-7401 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 reasons of health or utilization of Benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

CONTINUATION OF GROUP 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.

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 otherwise lose coverage because of a Qualifying Event that occurs while the contract holder 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 immediately 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):

*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.

- 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 Subscriber from the Dependent spouse 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, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
 4. With respect to any of the above, 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, termination of a domestic partner 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 of California 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 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.

COORDINATION OF BENEFITS

Coordination of benefits is designed to provide maximum coverage for dental bills at the lowest cost by avoiding excessive payments.

When a Member who is covered under the 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 Member will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual 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 services and supplies covered under at least one of the plans involved) up to the maximum benefit amount payable by each plan separately.

If the covered 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 the Plan.

The following rules determine the order of benefit 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 medical, 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.
3. 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:
 - a. 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
 - b. 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 (a.) above shall not apply.

If the Plan is the primary carrier with respect to a covered Member, then the Plan will provide its benefits without

reduction because of benefits available from any other plan, except that Participating Dentists may collect any difference between their billed charges and the Plan's payment, from the secondary carrier(s).

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 the Plan is secondary in the order of payments, and Blue Shield of California and a contracted Dental Plan Administrator are 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, the Plan will pay the benefits that would be due as if it were the primary plan, provided that the covered Member (1) assigns to a contracted Dental Plan Administrator or Blue Shield of California the right to receive benefits from the other plan to the extent of the difference between the benefits which a contracted Dental Plan Administrator or Blue Shield of California actually pays and the amount that a contracted Dental Plan Administrator or Blue Shield of California would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with a contracted Dental Plan Administrator or Blue Shield of California in obtaining payment of benefits from the other plan, and (3) allows Blue Shield of California or 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 the 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 the 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 the Plan shall furnish Blue Shield with such information as may be necessary to implement these provisions.

REIMBURSEMENT PROVISIONS

PROCEDURE FOR FILING A CLAIM

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

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

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

NON-ASSIGNABILITY

Coverage or any Benefits of the Blue Shield of California dental plans are not assignable without the written consent of Blue Shield of California.

Possession of a Blue Shield of California ID card confers no right to Services or other Benefits of the Plan. To be entitled to Services, the Member must be a Subscriber or Dependent who has been accepted by the Employer and enrolled by Blue Shield of California and who has maintained enrollment under the terms of the Plan.

The coverage and Benefits of the Blue Shield of California dental plans are assignable to Participating and Non-Participating Dentists.

CLAIMS REVIEW

Blue Shield of California and a contracted Dental Plan Administrator reserve the right to review all claims to determine whether any exclusions or limitations apply.

Blue Shield of California or a contracted Dental Plan Administrator may use the services of physician consultants, peer review committees of professional societies or hospitals, and other consultants to evaluate claims.

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 Subscriber or Member's eligibility, or payments on fraudulent claims.

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 health care services to them, their families, and the public (Health and Safety Code, Section 1369).

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

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

PROCEDURE

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 ten 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 Customer Service Department at the number listed in the Customer Service 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 neces-

sary 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.

INDEPENDENT CONTRACTORS

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 physician, hospital, or other provider or their employees.

DEFINITIONS

Whenever any of the following terms are capitalized in this booklet, they will have the meaning stated below:

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

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

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

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

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

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

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

Deductible — the Calendar Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

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

1. Services which are Dentally Necessary include only those which have been established as safe and effective 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 provider; 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 Services that can be provided for the condition, Blue Shield Life will provide benefits based on the most cost-effective Service.***

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

Dentist — a licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DDM).

Dependent — the spouse or registered Domestic Partner, or child, of an eligible Employee, who is determined to be eligible and who is not independently covered as an eligible Employee or Subscriber.

- 1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.
- 2) A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner as defined in the Contract.
- 3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, 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. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless

the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

- 4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:
 - a) the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
 - b) the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and
 - c) thereafter, certification of continuing disability and dependency from a Physician must be submitted to Blue Shield on the following schedule:
 - (i) within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and
 - (ii) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

Domestic Partner — an individual who is personally related to the Subscriber by a domestic partnership.

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

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.

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 the Plan to the contractholder that establishes the Services that Subscribers and Dependents are entitled to receive from the Plan.

Implants — artificial materials including synthetic bone grafting materials which are implanted into, onto or under bone or soft tissue, or the removal of implants (surgically or otherwise).

Member — either a Subscriber or an eligible Dependent.

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

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.

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

Plan — the Blue Shield of California Dental PPO Plan and/or Blue Shield of California.

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 Employee as defined, who has been enrolled and accepted by Blue Shield of California as a member of the group contract and has maintained his or her Blue Shield of California coverage under the terms of this group contract.

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

免費語言服務。 您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-346-7198與我們聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị 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 tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198 번으로 문의해 주십시오. Korean

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

Անվճար Լեզվախոս Ծառայություններ: Հոսք կարող եք թարգմանն ձեր բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ գտնված հարկ էր ինքնության (ID) տոմսի վրա նշված կամ 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、ID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

خدمات مجاني مربوط به زبان. می‌توانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی بر اینان خوانده شود. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است و با این شماره 1-866-346-7198 تماس بگیرید. Persian

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਆਰਾ ਦੇ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាសនៈសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដៃលម្អិត បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

Cov Key Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim 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, CA 95927

