This Disclosure Form is currently under review by our state regulator and could be subject to changes through that review process. We expect the review to be complete and the final document posted and available by September 1st, 2024.

Disclosure

Dental INO Plan Disclosure Form

Blue Shield Disclosure Form:

Dental INO Plan

This Disclosure Form is only a summary of your dental Plan. The Group Dental Service Contract, which you can obtain from your Employer, should be consulted to determine the terms and conditions governing your coverage. The Group Dental Service Contract is on file with your Employer and a copy will be furnished upon request.

The Evidence of Coverage (EOC) booklet describes the terms and conditions of coverage of your Blue Shield dental Plan. It is your right to view the EOC prior to enrollment in the dental Plan.

To obtain a copy of the EOC or if you have questions about the Benefits of the Plan, please contact the Dental Customer Service Department at (888) 702-4171. The hearing impaired may contact Customer Service by calling the TTY number at (800) 241-1823.

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

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

IMPORTANT

THIS IN-NETWORK ONLY DENTAL PLAN DOES NOT PAY BENEFITS TO NON-NETWORK PROVIDERS.

If you opt to receive dental services that are not Covered Services under this Plan, a participating Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Member Services at (888) 702-4171 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Disclosure document.

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

This dental INO Plan (in-network only plan, also known as exclusive provider organization plan) is specifically designed for you to use Participating Dentists (in network). If you choose to use Non-Participating Dentists (non-network dentists), those services will not be covered and you will have to pay all charges yourself. You can control your out-of-pocket costs by carefully choosing Participating Dentists to provide your Covered Services. A Dental Plan Administrator (DPA) has a network of Participating Dentists. To select a Participating Dentist, see the section below entitled "Before Obtaining Dental Services".

IMPORTANT

All Covered Services, except for Emergency Services, must be provided by Participating Dentists. No Benefits are provided when you receive services from a Non-Participating Dentist, except for Medically Necessary Covered Services received for emergency care. If a Participating Dentist refers you to a Non-Participating Dentist, you are responsible for the total amount billed by the Non-Participating Dentist (billed charges).

Choice of Dentists

Participating Dentists agree to accept a contracted Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Coinsurance, as payment in full for Covered Services.

Participating Dentists submit claims for payment after their services have been rendered. These payments go directly to the Participating Provider. A contracted Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

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. This contractual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the Policy. 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 1-888-702-4171. 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 the Dental Plan Administrator's network of Participating Dentists. Contact Customer service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services

If a 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.

Utilization Review

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

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

To request a copy of the document describing this Utilization Review process, call the Customer Service Department at 1-888-702-4171.

Principal Benefits and Coverages

The Benefits of the Plan are listed in the Summary of Benefits which is inserted as part of this booklet. Blue Shield payments for these services, if applicable, are also listed in the Summary of Benefits.

Covered Services

Implants - (Note: If your Plan provides Special Implant Benefits, see below.)

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) are not Benefits.

Special Implant Benefits - (Note: This limitation applies if your Plan provides special implant benefits.) The Member must obtain precertification/ prior authorization for these Benefits before services are provided or Benefits will be denied.

Crowns - Benefits are not provided for crowns, onlays, laminate veneers, or other cast or laboratory prepared restorations if the tooth can be restored with a filling material (e.g., amalgam, composite resin, or silicate cement).

General Anesthesia - Benefits are not provided for general anesthesia or intravenous sedation except as administered by a licensed Dentist in connection with a covered oral surgical procedure.

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 with respect to:

1. charges for services in connection with any treatment to the gums for tumors, cysts, and neoplasms;
2. charges for Implants or the removal of implants (surgically or otherwise) and any appliances and/or crown attached to Implants unless your plan provides special implant benefits. Please see the Summary of Benefits to determine if you have implant benefits;
3. services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if a Dental Plan Administrator or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by a Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;
4. charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint;
5. congenital mouth malformations or skeletal imbalances, including treatment required as the result of orthognathic surgery, Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
6. all prescription and non-prescription drugs;
7. charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
8. services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;
9. services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;
10. procedures which are principally cosmetic in nature, such as bleaching, veneers, and personalization or characterization of dentures;
11. the replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) within five (5) years of its installation;
12. myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures;
13. orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;
14. charges for services in connection with orthodontia, except as listed under Orthodontic services;
15. alloplastic bone grafting materials;
16. bone grafting done for socket preservation after tooth extraction or in preparation for Implants (unless your Plan provides special implant benefits. Please see the Summary of Benefits to determine if you have implant benefits.);
17. charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
18. extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
19. any procedure not performed in a dental office setting; except for general anesthesia when Medically Necessary;
20. dental services performed in a hospital or any related hospital fee;
21. any service, procedure, or supply for which the prognosis for long term success is not reasonably

favorable as determined by a Dental Plan Administrator and its dental consultants;

22. for which the Member is not legally obligated to pay, or for services for which no charge is made;
23. treatment as a result of Accidental Injury including setting of fractures or dislocation;
24. treatment for which payment is made by any governmental agency, including any foreign government;
25. charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
26. charges for onlays or crowns installed as multiple abutments;
27. any inlay restorations;
28. charges for dental appointments which are not kept, except as specified under the Summary of Benefits;
29. charges for services incident to any intentionally self-inflicted injury;
30. general anesthesia including intravenous and inhalation sedation, except when of Medical Necessity.
31. General anesthesia is considered Medically Necessary when its use is:
    a. in accordance with covered oral surgery procedures and generally accepted professional standards; and
    b. not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; or
    c. due to the existence of a specific medical condition;
32. Patient apprehension or patient anxiety will not constitute Medical Necessity.
33. A Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Medical Necessity;
34. removal of 3rd molar (wisdom teeth) other than for Medical Necessity. Medical Necessity pertaining to the removal of 3rd molar; (wisdom teeth) is defined as a pathological condition which includes horizontal, mesial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not Medical Necessity;
35. periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;
36. any service, procedure, or supply which is received or expenses incurred prior to the patient's effective date of coverage;
36. for services provided by an individual or entity that is not licensed or certified by the state to provide health-Dental Care Services, or is not operating within the scope of such license or certification, except as specifically stated herein;
37. charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
38. any and all Implant services that have not been prior authorized and approved by a Dental Plan Administrator if your Plan provides special implant benefits. Implants that are used as an abutment, double abutment, or bone anchor to support or hold a fixed bridge, orthodontic appliance, removable prosthesis, or oral-maxillofacial prosthesis are not covered.

Orthodontic Limitations and Exclusions

1. treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
2. surgical Orthodontics (including extraction of teeth) incidental to Orthodontic treatment;
3. treatment for myofunctional therapy;
4. changes in treatment necessitated by an accident;
5. treatment for TMJ (Temporomandibular Joint) disorder or dysfunction;
6. ceramic braces which are considered to be cosmetic;
7. special Orthodontic appliances, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
8. replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
9. treatment exceeding twenty-four (24) months for treatment prior approved by Blue Shield as Medically Necessary;
10. in the event of a Member's loss of coverage for any reason, if at the time of loss of coverage the Member is still receiving Orthodontic treatment during the twenty-four (24) month treatment period, the Member and not the Dental Plan Administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's Billed Charges, prorated for the number of months remaining;
11. if the Member is reinstated after cancellation, there are no Orthodontic benefits for treatment begun prior to his or her reinstatement effective date;

13. if the Member elects to use invisalign®, lingual or invisible braces, sapphire or clear braces, additional costs beyond what Blue Shield will pay for "standard" Orthodontic system of brackets and wires will be paid by the Member.

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

Medical Necessity Exclusion

All services must be of Medical Necessity. The fact that a Dentist or other Participating Dentist may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Medical Necessity even though it is not specifically listed as an exclusion or limitation, Blue Shield may limit or exclude Benefits for services which are not of Medical Necessity.

Alternate Benefit Provision

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

General Limitations

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

1. one (1) in a six (6) month period:
    A. periodic oral exam;
    B. fluoride treatment;
    C. bitewing x-rays (two sets of single films or one set of two films);
    D. recementations if the crown or inlay was provided by other than the original Dentist; not eligible if the Dentist is doing the recementation of a service he/she provided within twelve (12) months;
    E. [periodontal maintenance;]
2. one (1) in a twelve (12) month period:
    A. denture (complete or partial) reline;
    B. oral cancer screening;
    C. bitewing x-rays (three films or four films);
3. one (1) in twenty-four (24) months:
    A. sealants;
    B. occlusal guards;
    C. diagnostic casts;
    D. gingival flap surgery per quad;
    E. scaling and root planing per quadrant;
    F. [full mouth series and panoramic x-rays.]
4. one (1) in thirty-six (36) months:
    A. mucogingival surgery per area;
    B. osseous surgery per quad;
    C. gingivectomy per quad;
    D. gingivectomy per tooth;
    E. bone replacement grafts for periodontal purposes;
    F. guided tissue regeneration for periodontal purposes;
    G. full mouth series and panoramic x-rays;
    H. full mouth debridement;
    I. intraoral x-rays – complete series including bitewings;
    J. panoramic film;
5. one (1) in a five (5) year period:
    A. [single crowns and onlays;]
    B. single post and core buildups;
    C. crown buildup including pins;
    D. prefabricated post and core;
    E. cast post and core in addition to crown;
    F. complete dentures;
    G. partial dentures;
    H. fixed partial denture (bridge) pontics;
    I. fixed partial denture (bridge) abutments;
    J. abutment post and core buildups
6. two (2) in a consecutive twelve (12) month period:
    A. routine prophylaxis;
7. space maintainers – only eligible for Members when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop;
8. sealants – one (1) per tooth per two-year period through the end of the month in which the Member turns nineteen (19) on permanent first and second molars;
9. child fluoride – one (1) per six (6) month period through the end of the month in which the Member turns nineteen (19);
10. topical fluoride varnish; therapeutic application for moderate to high caries risk patients – three (3) in a twelve (12) month period;
11. oral surgery services are limited to removal of teeth, bony protuberances and frenectomy;
12. an Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the Dentist. For example, an alternate benefit of a partial denture will he applied when there are bilaterally missing teeth or more than three (3) teeth missing in one quadrant or in the anterior region. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP;
13. general or IV sedation is covered for:
    A. three (3) or more surgical extractions;

B. any number of Medically Necessary impactions;
C. full mouth or arch alveoloplasty;
D. surgical root recovery from sinus;
E. medical problem contraindicates the use of local anesthesia;
F. children under the age of seven (7) years old.

14. General or IV sedation is not a covered benefit for dental phobic reasons. Deep sedation/general anesthesia is covered for up to one hour per visit;
15. restorations, crowns, inlays and onlays - covered only if necessary to treat diseased or accidentally fractured teeth;
16. root canal treatment – one (1) per tooth per lifetime;
17. root canal retreatment – one (1) per tooth per lifetime;
18. for mucogingival surgeries, one (1) site is equal to two (2) consecutive teeth or bounded spaces;
19. scaling and root planing – covered once for each of the four quadrants of the mouth in a twenty-four (24) month period. Scaling and root planing is limited to two (2) quadrants of the mouth per visit;
20. you must be age twenty-one (21) or older to be eligible for dental implant benefits due to continued growth and development of the mid face and jaws. If there are bilaterally missing teeth and/or non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If there are more than three teeth missing and/or more than three non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If the Member elects a different procedure, payment will be based on the partial denture Benefit;
21. Cone Beam CT (D0367) is a benefit only when placing an implant. This procedure cannot be used for Orthodontics or Periodontics. This is a once in a lifetime Benefit and is limited to projection of upper and lower jaws only.

Prepayment Fees

The monthly Dues for you and your Dependent are indicated in your Employer's group Contract. The initial Dues are payable on the effective date of the group Contract, and subsequent Dues are payable on the same date of each succeeding month. Dues are payable in full on each transmittal date and must be made for all Subscribers and Dependents.

All Dues required for coverage for you and your Dependents will be handled through your Employer, and must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this group Contract up to the date immediately before the next transmittal date, but not thereafter.

The Dues payable under this Plan may be changed from time to time, for example, to reflect new Benefit levels. Your Employer will receive notice from the Plan of any changes in Dues at least 60 days prior to the change. Your Employer will then notify you immediately. Note: This paragraph does not apply to a Subscriber who is enrolled under a contract where monthly Dues automatically increase, without notice, the first day of the month following an age change that moves the Subscriber into the next higher age category.

Other Charges

Calendar Year Deductible

For dental Plans with a Calendar Year Deductible, the Deductible applies to all Covered Services and supplies furnished by Participating Dentists, except as specified in the Summary of Benefits which is attached to and made a part of this Disclosure Form. It is the amount which you must pay out of pocket for charges that would otherwise be payable for Dental Care Services and supplies. Charges in excess of the Allowable Amount do not apply toward the Deductible. This per Member Deductible applies separately to each covered Member each 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 Disclosure Form.

Payment and Subscriber Coinsurance Amount Responsibilities

After any applicable Deductible has been satisfied, payments will be provided based on the Allowable Amount determined by a Dental Plan Administrator, to Participating Dentists for the Benefits of this Plan, subject to the Coinsurance amount 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 Participating Dentists is listed in the Summary of Benefits which is attached to and made a part of this Disclosure Form.

*NOTE: If your Plan provides Benefits for orthodontia, a separate Benefit maximum applies to Orthodontic services. See the Summary of Benefits which is attached to and made a part of this Disclosure Form.

Out-Of-Pocket Maximum

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

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 Dental Plan Administrator, at http://www.blueshieldca.com or any Blue Shield of California office. Have your Dentist complete the form and mail it to a Dental Plan Administrator Service Center shown on the last page of this booklet.

A 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 Dental Plan Administrator within one (1) year after the month in which the service is rendered. A Dental Plan Administrator will notify you of its determination within 30 days after the receipt of the claim.

Renewal Provisions

The Group Dental Service Contract is issued for a one year period.

Plan Changes

The Benefits of this Plan, including but not limited to Covered Services, Deductible, and Coinsurance amount, 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.

Individual Continuation of Benefits

Cal-COBRA Coverage

State law provides that Subscribers who enroll in a group plan and later lose eligibility may be entitled to continuation of group coverage. Please refer to the EOC for information regarding your eligibility for Cal-COBRA.

COBRA Coverage

If your employment with your current Employer ends, you and your covered Family Members may qualify for continued group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The section in the EOC entitled Continuation of Group Coverage has information on COBRA.

Termination of Benefits

Blue Shield may terminate coverage if:

(1) There is a violation of a material contract provision relating to Employer contribution or group participation rates by the Contractholder/Employer;

(2) Blue Shield terminates a particular product or all products offered in the large group market as permitted or required by law. If Blue Shield discontinues offering a particular product in a market, Blue Shield will send you written notice at least 90 days before the product terminates. If Blue Shield discontinues offering all products to groups in the large group market, Blue Shield will send you written notice at least 180 days before the Contract terminates;

(3) A Member or Employer ceases to be a member of a guaranteed association.

Group Termination

Blue Shield may cancel the Contract for non- payment of Dues.

If the Employer fails to pay the required Dues when due, coverage will end 30 days after the date for which Dues are due. Your Employer will be liable for all Dues accrued while this Plan continues in force including those accrued during the 30 day grace period.

If Blue Shield's Group Dental Service Contract is terminated, you will no longer receive Benefits – including COBRA or Cal-COBRA coverage. Exceptions due to a disability are specifically outlined in the Extension of Benefits provision in the EOC.

Individual Termination

In addition to termination of your Employer's Group Dental Service Contract with Blue Shield, you will no longer be eligible for coverage under the Plan if:

1. You no longer meet the eligibility requirements in your Employer's Group Dental Service Contract;
2. You engage in fraud or deception in the use of dental Plan Benefits.

Please refer to the EOC or your Employer's Group Dental Service Contract for additional information.

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.

Grievance Process

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

External Independent Medical Review

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

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan **1-800-424-6521** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health Plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in Nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **1-888-466-2219** and a TDD line **1-877-688-9891** for the hearing and speech impaired. The Department's internet website **(http://www.dmhc.ca.gov)** has complaint forms, IMR application forms, and instructions online.

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

Confidentiality of Personal and Health Information

Blue Shield 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 DENTAL 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

Coordination of Benefits

For more detailed information about Blue Shield's Coordination of Benefits procedure, please refer to the Evidence of Coverage (EOC), or call customer service at 1-888-702-4171.

Definitions

Terms used throughout this Disclosure Form are defined as follows:

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

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 Dental Plan Administrator Allowance is:

1. the amount the Dental Plan Administrator has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based upon such factors 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 Participating Dentist and a 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 Dental Plan Administrator determines is appropriate considering the particular circumstances and the services rendered.

Alternate Benefit Provision (ABP) - a provision that allows Benefit paid to be based on an alternate procedure, which is professionally acceptable and more cost effective.

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

Billed Charges - the prevailing rates of the Dental office.

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

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

Coinsurance - the percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

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

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

Deductible - the Calendar Year amount 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 Care Services - necessary treatment on or to the teeth or gums, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

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

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

Dentist - a licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

Dependent -

1. a Subscriber's legally married spouse who is:

   a. not covered for Benefits as a Subscriber;

   and

   b. not legally separated from the Subscriber;

   or,

2. a Subscriber's Domestic Partner who is not covered for Benefits as a Subscriber;

   or,

3. a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber who is 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) and who has been enrolled and accepted by Blue Shield of California as a Dependent and has maintained membership in accordance with the Contract.

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

4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:

   a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

   b. the Subscriber, spouse, or Domestic Partner submits to Blue Shield 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 is submitted to Blue Shield on the following schedule:

      (1) within twenty-four (24) months after the month when the Dependent would otherwise have been terminated; and

      (2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

Domestic Partner - an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1) Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;

2) The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;

3) The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;

4) Both partners are capable of consenting to the domestic partnership; and

5) The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this Plan. If permitted by your Employer, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code).

The domestic partnership is deemed created on the date when both partners meet the above requirements.

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

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

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

Employee - an individual who meets the eligibility requirements set forth in the Group Dental Service Contract between Blue Shield of California and your 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).

Medical Necessity (Medically Necessary)
Benefits are provided only for services that are Medically Necessary.

1. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted national and California dental standards to treat illness, injury or dental condition, and which are:
   a. consistent with generally accepted standards of dental practice referenced in the Dental Plan Administrator's dental policy;
   b. consistent with the symptoms or diagnosis;
   c. not furnished primarily for the convenience of the patient, the attending Dentist or other provider;
   d. furnished at the most appropriate level which can be provided safely and effectively to the patient; and
   e. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or dental condition.

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 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 transfer from another health benefit plan sponsored by the Employer to this Plan.

Orthodontics (Orthodontic) - Dental Care Services specifically related to necessary services for the treatment for malocclusion and the proper alignment of teeth.

Participating Dentist - a Doctor of Dental Surgery or a Doctor of Dental Medicine who has signed a service contract

with a Dental Plan Administrator to provide dental services to Subscribers.

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

Plan - the Blue Shield of California Dental INO Plan and/or Blue Shield of California.

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.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。