Disclosure

Smile℠ D&P In-Network Only Dental Disclosure Form

An independent licensee of the Blue Shield Association

Blue Shield Life Disclosure Form:

NOTICE

This Disclosure Form is only a summary of the Plan. You have the right to review the Group Dental Policy, which you can obtain from your Employer upon request, to determine the terms and conditions governing your coverage

The Certificate of Insurance contains the terms and conditions of coverage of your Blue Shield of California Life & Health Insurance Company (Blue Shield Life) dental Plan. It is your right to view the Certificate of Insurance prior to enrollment in the dental Plan.

Please read the Disclosure Form and Certificate of Insurance 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 Life provides you with a Matrix summarizing key elements of the Blue Shield Life 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 Life Customer Service at the address or telephone number listed at the back of this booklet.

NOTICE

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

Dental INO Plan

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

The Certificate of Insurance (COI) booklet describes the terms and conditions of coverage of your Blue Shield Life dental plan. It is your right to view the COI prior to enrollment in the dental plan.

To obtain a copy of the COI or if you have questions about the Benefits of the Plan, please contact the Dental Customer Service Department at (888) 679-8928. The hearing impaired may contact Customer Service by calling the TTY number at (977) 218-7138.

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 benefit summary, summarizing key elements of the Blue Shield Life group dental Plan you are being offered, is provided with this Disclosure Form to assist you in comparing dental plans available to you.

IMPORTANT

If you opt to receive dental services that are not Covered Services under this Plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 1-888-702-4171 or your insurance broker. To fully understand your coverage, you may wish to carefully review the Certificate of Insurance document you have been provided.

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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 offers in-network only Diagnostc and Preventive Benefits and 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".

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

IMPORTANT

All Covered Services must be provided by Participating Dentists. No Benefits are provided when you receive services from a Non-Participating Dentist. 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 as payment in full for Covered Services.

Services rendered for diagnostic and preventive care will be paid at 100%, subject to certain limitations as specified in the section entitled "*Covered Services and Supplies*".

Participating Dentists submit claims for payment after Dental Care Services have been rendered. Payments for these claims go directly to the Participating Dentist

All claims for reimbursement must be submitted to a contracted Dental Plan Administrator within 1 year after the month of service. A Dental Plan Administrator will process your claim within 30 calendar days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. The Dental Plan Administrator cannot process your claim until we receive the missing information. Once the missing information is received, The Dental Plan Administrator will have 30 calendar days to process your claim.This contractual arrangement may include incentives to manage all services provided to Insureds 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 Life's Internet site located at http://www.blueshieldca.com.

Urgent and Emergency Dental Services

This Plan does not provide Benefits for Urgent or Emergency Services.

Liability of Subscriber or Enrollee for Payment

Services received from Non-Participating Dentists are not covered. You are responsible for assuring that the Dentist you choose is a Participating Dentist.

Note: A Participating Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dentist, in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located in your area can be obtained by contacting a contracted Dental Plan Administrator at 1-888-702-4171. You may also access a list of Participating Dentists through Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Facilities

Directories of Participating Dentists are available on our website http://www.blueshieldca.com or by calling 1-888-702-4171.

Financial Responsibility for Continuity of Care Services

If an Insured is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Insured 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 dental provider in the same geographic area.

Utilization Review

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

Blue Shield Life has completed documentation of this process ("Utilization Review"), as required under Section 10123.135 of the California Insurance Code.

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

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 Life payments for these services, if applicable, are also listed in the Summary of Benefits.

COVERED SERVICES AND SUPPLIES

Benefits of the Plan are provided when performed by a Participating Dentist. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Policy, to any conditions or limitations set forth in the Benefit descriptions below, and to the limitations and exclusions listed in this Disclosure Form.

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

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

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, is operating within the scope of that license or certification, and is a Participating Dentist.

Diagnostic and Preventive Services

Diagnostic and preventive services including routine oral exams, X-rays, cleanings, oral cancer screening, and caries risk management (CAMBRA) procedures provided by Participating Dentists will be covered at 100%, subject to the limitations in the *General Limitations* section and are not subject to the Calendar Year Deductible.

Enhanced Dental Benefits for Pregnant Women

This Plan provides additional or enhanced Benefits for certain services for women who are pregnant.

1. One (1) additional routine adult prophylaxis including periodontal prophylaxis for gingivitis for women during pregnancy. Note: This prophylaxis is in addition to the prophylaxis provided under this section entitled *Diagnostic and Preventive Services*;
2. One (1) periodontal maintenance visit if warranted by a history of periodontal treatment; and
3. One (1) course of up to four (4) quadrants of periodontal scaling and root planing for women during pregnancy with a documented existing periodontal condition [1].

[1] If these services are required outside of pregnancy, services will not be covered.

LIMITATIONS AND EXCLUSIONS

If you have questions about limitations and exclusions for specific dental procedures, please contact Dental Customer Service at the number at the end of this booklet.

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. dental services not appearing on the Summary of Benefits;
2. Urgent and Emergency Services;
3. services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if a contracted Dental Plan Administrator or Blue Shield Life provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by a contracted Dental Plan Administrator or Blue Shield Life for the treatment of such injury or disease;
4. all prescription and non-prescription drugs;
5. charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
6. services, procedures, or supplies that are not Medically Necessary for the care of the Insured's dental condition or which are Experimental or Investigational in Nature;
7. procedures which are principally cosmetic in nature, such as bleaching, veneers, and personalization or characterization of dentures;
8. myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures;
9. charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
10. any procedure not performed in a dental office setting;
11. dental services performed in a hospital or any related hospital fee;
12. any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;
13. services for which the Insured is not legally obligated to pay, or for services for which no charge is made;

14. treatment for which payment is made by any governmental agency, including any foreign government;
15. charges for dental appointments which are not kept;
16. charges for services incident to any intentionally self-inflicted injury;
17. charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
18. any service, procedure, or supply which is received or expenses incurred prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have had expenses incurred is defined as follows:
    a. for full dentures or partial dentures: on the date the final impression is taken;
    b. for fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
    c. for root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex;
    d. for periodontal surgery: on the date the surgery is actually performed;
    e. for all other services: on the date the service is performed; and
19. 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.

General Limitations

The following services, if listed on the schedule 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. routine prophylaxis;
   C. fluoride treatment; and
   D. bitewing x-rays (two sets of single films or one set of two films).
2. one (1) in a twelve (12) month period:
   A. full set of dental x-rays;
   B. comprehensive periodontal evaluation with a car ries risk assessment;
   C. oral cancer screening (specify); and
   D. bitewing x-rays (three films or four films).
3. one (1) in thirty-six (36) months:
   A. full mouth series and panoramic x-rays;
   B. intraoral x-rays – complete series including bitewings; and
   C. panoramic film.
4. sealants – one (1) per tooth per two-year period through age seventeen on permanent first and second molars;
5. child fluoride and child prophylaxis – one (1) per six (6) month period through the end of the month the Insured turns nineteen (19); and
6. topical fluoride varnish; therapeutic application for moderate to high caries risk patients – three (3) in a twelve (12) month period.

Limitation on Liability of Subscribers

In accordance with Blue Shield Life's established policies, and by statute, every Policy 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 Policy. When services are provided by a Participating Dentist, the Subscriber is responsible for any applicable Deductible, Coinsurance amounts, and charges in excess of Benefit maximums.

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

The monthly Premiums for you and your Dependents are indicated in your Employer’s group policy. The initial Premiums are payable on the effective date of the group Policy, and subsequent Premiums are payable on the same date (called the transmittal date) of each succeeding month. Premiums is payable in full on each transmittal date and must be made for all Subscribers and Dependents.

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

The Premiums 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 Premiums 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 policy where monthly Premiums automatically increase, without notice, the first day of the month following an age change that moves the Subscriber into the next higher age category.

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 Life 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 Life Online

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

Choice of Providers

Under this Blue Shield Life INO Dental Plan, you have a choice of any Participating Dentist.

The names of Participating Dentists in your area may 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 Life's Internet site located at http://www.blueshieldca.com.

Grievance Process

Blue Shield Life has established a grievance procedure for receiving, resolving, and tracking Insureds' grievances with Blue Shield Life. For more information on this process, see the Grievance Process section in the COI.

California Department of Insurance Review

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured or his or her provider.

If you have a complaint against Blue Shield of California Life & Health Insurance Company, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8 a.m. – 5 p.m., Monday – Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013, or through the website http://www.insurance.ca.gov/contact-us/0200-file-complaint.

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

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 Insureds when the Subscriber's Employer (Policyholder) 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 Insured will be entitled to elect to continue group coverage under this Plan if the Insured would otherwise lose coverage because of a Qualifying Event (defined in the COI) that occurs while the policy 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 Insured if the Qualifying Event had not occurred (including any changes in such coverage).

Note: An Insured will not be entitled to benefits under Cal-COBRA if at the time of the Qualifying Event such Insured 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, an Insured is entitled to Benefits if at the time of the qualifying event such Insured 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.

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 Insured 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 Insured 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 or-

der 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 Insured 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 stepparent 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 Insured, 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 Life 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 Insured (1) assigns to a contracted Dental Plan Administrator or Blue Shield Life 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 Life actually pays and the amount that a contracted Dental Plan Administrator or Blue Shield Life would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with a contracted Dental Plan Administrator or Blue Shield Life in obtaining payment of Benefits from the other plan, and (3) allows Blue Shield Life 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 Life 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 Life shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by Blue Shield Life in excess of the maximum amount of payment necessary to satisfy these provisions, Blue Shield Life 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 Life may release to or obtain from any organization or person any information which Blue Shield Life 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 Life with such information as may be necessary to implement these provisions.

Confidentiality of Personal and Health Information

Blue Shield Life 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 Life will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield Life'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 Life's internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield Life 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 Life Privacy Official

P.O. Box 272540

Chico, CA 95927-2540

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

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.

Basic Services - the category of dental services that usually includes restorations (fillings), oral surgery (extractions), endodontics (root canals), periodontal treatment (root planing) and sealants.

Benefits (Covered Services) – those services which an Insured is entitled to receive pursuant to the Group Dental Service Policy.

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 of the Allowable Amount that an Insured is required to pay for specific Covered Services after meeting any applicable Deductible.

Covered Services (Benefits) – those services which an Insured is entitled to receive pursuant to the terms of the Group Dental Policy.

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 Plan Administrator (DPA) – a DPA is an entity that contracts with Blue Shield Life to administer the delivery of dental services through a network of Participating Dentists.

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 and who has been enrolled and accepted by Blue Shield Life as a Dependent and

has maintained membership in accordance with the Policy.

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 Life a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield Life's request; and

   c. thereafter, certification of continuing disability and dependency from a Physician is submitted to Blue Shield Life on the following schedule:

      (1) within 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 each other'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.

Emergency Services – **s**ervices 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 Policy between Blue Shield Life and your Employer.

Employer (Policyholder) – any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 2 Employees 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 Policy (Policy) – the policy issued by the Plan to the Policyholder that establishes the services that Subscribers and Dependents are entitled to receive from the Plan.

Insured – either a Subscriber or an eligible Dependent.

Major Services - the category of dental services that usually includes crowns, dentures, and oral surgery. Implants would also be included in this category if a covered Benefit of your Plan.

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 Blue Shield Life's dental policies that ensure decisions based on Medical Necessity are supported by clinical principles and processes. Such policies are available upon request;
    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 of care 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 Insured's illness, injury, or dental condition.

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. Services received from Non-Participating Dentists are not covered.

Open Enrollment Period – that period of time set forth in the policy during which eligible Employees and their Dependents may transfer from another health benefit plan sponsored by the Employer to this Plan.

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

Plan – the Blue Shield Life INO Dental Plan and/or Blue Shield Life.

Premiums – the monthly pre-payment that is made to the Plan on behalf of each Insured.

Subscriber – an Employee as defined, who has been enrolled and accepted by Blue Shield Life as a member of the group policy and has maintained his or her Blue Shield Life coverage under the terms of this group policy.

Urgent Services — those services rendered outside of the Plan Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury, or complications of an existing dental condition, for which treatment cannot reasonably be delayed until the Member returns to the Plan Service Area.

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 Service 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 Servicio 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)**。