Dental PPO Smile™ Plan

Combined Evidence of Coverage and Disclosure Form
California-Nevada Annual Conference of the United Methodist Church
Effective Date: January 1, 2011
NOTICE

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

Please read this Evidence of Coverage and Disclosure Form 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.

NOTICE

Please read this Evidence of Coverage and Disclosure Form 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 or upon renewal. 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.
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Smile SpectrumSM 50/1000/No Ortho/MAC

Note: See the end of this Summary of Benefits for important benefit footnotes.

## Summary of Benefits

<table>
<thead>
<tr>
<th>Member Calendar Year Deductible (Dental Plan Deductible)</th>
<th>Deductible Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating Dentists</td>
</tr>
<tr>
<td>The deductible applies to all covered Services incurred except for Diagnostic and Preventive Services and Enhanced Dental Benefits for Pregnant Women provided by Participating Dentists or Non-Participating Dentists.</td>
<td>$50 per Member / $150 per Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Calendar Year Payment</th>
<th>Maximum Blue Shield Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating Dentists</td>
</tr>
<tr>
<td>For all covered Services</td>
<td>$1,000 per Member$^1</td>
</tr>
<tr>
<td>The Plan pays up to the maximum payment amount as listed for covered Services and supplies.</td>
<td></td>
</tr>
</tbody>
</table>

### Covered Services and Supplies

<table>
<thead>
<tr>
<th>Covered Services and Supplies</th>
<th>Blue Shield Payment Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating Dentists</td>
</tr>
<tr>
<td>Diagnostic and Preventive Services</td>
<td>100%</td>
</tr>
<tr>
<td>Enhanced Dental Benefits for Pregnant Women</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
</tr>
<tr>
<td>Major Services</td>
<td>50%</td>
</tr>
</tbody>
</table>

$^1$ The Plan pays up to this maximum payment amount for all covered Services and supplies received from any combination of Participating and Non-Participating Dentists.
This Summary of Benefits is a supplement to and a part of the Dental PPO Evidence of Coverage and Disclosure Form (EOC). The provisions contained in this Summary of Benefits are described in detail in the EOC.

This Summary of Benefits describes the Dental Services (Benefits) covered by this Plan. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the EOC and to any conditions or limitations set forth in the benefit descriptions below.

**Precertification of Dental Benefits Program**

Before any course of treatment expected to cost more than $250 is started, you should obtain Precertification of Benefits. See the Precertification of Dental Benefits Program section of the EOC for a complete description of requirements.

**Covered Services and Supplies**

The covered Services and supplies listed below are payable at the applicable Copayment percentage of the Allowable Amount as specified under the Blue Shield's Payment Percentage section of this Summary of Benefits. These Services are subject to all applicable provisions of the Calendar Year Deductible, Blue Shield’s Maximum Calendar Year Payment, and Benefit Maximum sections of this Summary of Benefits, as well as all provisions of the EOC.

**Diagnostic and Preventive Services**

Clinical oral examinations, including consultations by a specialist (if diagnostic Service is provided by a Dentist or physician other than the practitioner providing treatment), not more than once in any period of 6 consecutive months.

Oral cancer screening not more than once in any period of 12 consecutive months.

Dental prophylaxis not more than once in any period of 6 consecutive months.

Topical application of fluoride not more frequently than once in any period of 6 consecutive months and only for eligible Members through the age of 17.

Periodontal prophylaxis (recall or maintenance visit) not more than a combined total of one periodontal and/or regular prophylaxis per each period of 6 consecutive months.

X-rays:

- Bitewing film not more than once in any period of 6 consecutive months. Full mouth series (includes 10 to 14 periapical x-rays and supplementary bitewing films) not more than once in any period of 24 consecutive months. In applying this 24 month limitation, a panoramic x-ray shall be considered a full mouth series.

X-rays required to diagnose a specific condition that needs treatment are not subject to limitations stated above.

Diagnostic casts not more than once in any period of 24 consecutive months. Working models taken in conjunction with a prosthetic or other appliance are not considered to be diagnostic casts.

**Enhanced Dental Benefits for Pregnant Women**

This Plan provides additional or enhanced benefits for certain services for women who are pregnant. When the benefits below are available, they are not subject to the Calendar Year Deductible when Services are provided by Participating Dentists, and the Subscriber is responsible for a lower copayment amount.

1. One additional routine adult prophylaxis including periodontal prophylaxis for gingivitis for women during pregnancy (Note: This prophylaxis is in addition to the prophylaxis provided under *Diagnostic and Preventive Services*); and

2. One periodontal maintenance visit if warranted by a history of periodontal treatment*; and

3. One course (up to 4 quadrants) of periodontal scaling and root planing for women during pregnancy with a documented existing periodontal condition*.

*Note: If these Services are required outside of pregnancy, coverage is available under the Periodontics Benefits of this Plan.

**Basic Services**

Anesthesia — General or intravenous sedation, only when provided in conjunction with a covered oral surgery procedure.

Endodontics — Pulp capping; therapeutic pulpotomy — deciduous teeth only (in addition to restoration); vital pulpotomy — deciduous teeth only; apexification; root canals on permanent teeth only, including pulpotomy or other palliative treatment and necessary X-rays and cultures, but excluding final restoration; root canal therapy; apicoectomy (including apical curettage).

Oral Surgery — Extractions; removal of impacted teeth; radical excision of small (to 1.25 cm) non-malignant lesions; other surgical procedures; includes local anesthesia and routine pre and post operative care.

Palliative — Emergency treatment for relief of pain.

Periodontics — Emergency treatment including but not limited to periodontal abscess and acute periodontitis; root planing (not prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post surgical visits).

Restorative Dentistry — Amalgam restorations; synthetic restorations (i.e. silicate cement filling, porcelain fill-
ing, plastic filling and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material.

Sealants — One treatment in any period of 24 consecutive months per each permanent molar and only for patients under age 18.

Space Maintainers — Includes all adjustments within 6 months after installation. Benefits for space maintainers are limited to eligible Dependent children through the age of 11.

MAJOR SERVICES

Cast Restorations — Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a filling material. Cast restorations (onlays, and other laboratory prepared restorations); crowns (acrylic, composite glass, porcelain and gold); veneers; post and cores; crown buildups (on vital or non-vital teeth when functionally necessary). There is no coverage for replacement of an existing crown, onlay, or other cast restoration which is less than 5 years old. Repair or recementing of onlays and crowns is covered for 6 months after installation.

Prosthetics — Bridges, dentures, partials and relining or rebasing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stay plate, special tissue conditioning per denture (limited to one course of treatment per 6 month period). Fees for appliances include adjustments, repairs, and relines for a 6 month period following installation. An additional Benefit for one reline per immediate denture is payable during the first 6 months following installation. There is no coverage for replacement of an existing partial denture, full removable denture or fixed bridgework which is less than 5 years old. Upgrading from a partial denture to fixed bridgework will be payable only if acceptable documentation is presented which clearly demonstrates that the patient's arch cannot be adequately restored with a partial denture.
INTRODUCTION TO THE BLUE SHIELD OF CALIFORNIA 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 1-888-702-4171. 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 1-888-702-4171. 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 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.

**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 Plan Administrator (DPA)** — Blue Shield of California has contracted with the Plan’s contracted 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 underwrite and administer delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

**Dentist** — a licensed Doctor of Dental Surgery.

**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 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 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 (a) 18 years of age or older and (b) of the same sex or different sex;
2. The partners share (a) an intimate and committed relationship of mutual caring and (b) the same principal residence;
3. The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

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.

**Employee** — an individual who:

1. is a non-retired Conference clergy member or an active pastor under Episcopal appointment to service a local church within the bounds of the Conference; or is employed by the Conference or a local church on an active, full-time basis with a work week of at least 30 hours, and whose duties in such employment are performed at the Employer’s usual place of business and who meets any other criteria specified by the Standing Rules of the California-Nevada Annual Conference of the United Methodist Church;
2. is a former Employee retired by a participating Conference group who is receiving a pension financed by the Employer and who meets any other criteria specified by the Standing Rules of the California-Nevada Annual Conference of the United Methodist Church.

**Employer (Contractholder)** — 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 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.

**Member** — either a Subscriber or an eligible Dependent.

**Non-Participating Dentist** — a Doctor of Dental Surgery 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 transfer from another health benefit plan sponsored by the Employer to this Plan.

**Participating Dentist** — a Doctor of Dental Surgery 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.

**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.

**Total Disability (or Totally Disabled)** —

1. in the case of an Employee or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual’s customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual’s station in life and physical and mental capacity;
2. in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual’s customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual’s station in life and physical and mental capacity.

**ELIGIBILITY**

If you are an Employee, you are eligible for coverage as a Subscriber the day following the date you complete the wait-
ing period established by your Employer. Your spouse or Domestic Partner and all your dependent children are eligible at the same time.

Newborn infants of the Subscriber, spouse, or his or her Domestic Partner will be eligible immediately after birth for the first 31 days. A child placed for adoption will be eligible immediately upon the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Subscriber's, spouse's or Domestic Partner's right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to and received by Blue Shield within 31 days from the date of birth or placement for adoption of such Dependent.

A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship, if an application is submitted within 31 days of becoming eligible.

You may add newly acquired Dependents and yourself to the Plan by submitting an application within 31 days from the date of acquisition of the Dependent:

1. to continue coverage of a newborn or child placed for adoption;
2. to add a spouse after marriage, or add a Domestic Partner after establishing a domestic partnership;
3. to add yourself and spouse following the birth of a newborn or placement of a child for adoption;
4. to add yourself and spouse after marriage;
5. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

A completed health statement may be required with the application. Coverage is never automatic; an application is always required.

If both partners in a marriage or domestic partnership are eligible to be Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician's written certification of such disabling condition. Blue Shield or the Employer will notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician's written certification within 60 days of the request for such information by the Employer or by Blue Shield. Proof of continuing disability and dependency must be submitted by the Employee as requested by Blue Shield but not more frequently than 2 years after the initial certification and then annually thereafter.

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

**Effective Date of Coverage**

Coverage will become effective for Employees and Dependents who enroll during the initial enrollment period at 12:01 a.m. Pacific Time on the eligibility date established by your Employer.

If, during the initial enrollment period, you have included your eligible Dependents on your application to Blue Shield, their coverage will be effective on the same date as yours. If application is made for Dependent coverage within 31 days after you become eligible, their effective date of coverage will be the same as yours.

When you do not enroll yourself or your Dependents during the initial enrollment period and later apply for coverage, you and your Dependents will be considered to be late enrollees. When late enrollees decline coverage during the initial enrollment period, they will be eligible the earlier of, 12 months from the date of application for coverage or at the Employer’s next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

You and your Dependents will not be considered to be late enrollees if either you or your Dependents lose coverage under another employer health plan and you apply for coverage under this Plan within 31 days of the date of loss of coverage. You will be required to furnish Blue Shield written proof of the loss of coverage.

Once each Calendar Year, your Employer may designate a time period as an annual Open Enrollment Period. During that time period, you and your dependents may transfer from another dental plan sponsored by your Employer to this Plan. A completed enrollment form must be forwarded to Blue Shield within the Open Enrollment Period. Enrollment becomes effective on the anniversary date of this Plan following the annual Open Enrollment Period.

Any individual who becomes eligible at a time other than during the annual Open Enrollment Period (e.g., newborn, child placed for adoption, child acquired by legal guardianship, new spouse or Domestic Partner, newly hired or newly transferred Employees) must complete an enrollment form within 31 days of becoming eligible.

Coverage for a newborn child will become effective on the date of birth. Coverage for a child placed for adoption will become effective on the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care, following submission of evidence of such control (a health facility minor release report, a medical authorization form or
a relinquishment form). In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by Blue Shield within 31 days. A Dependent spouse becomes eligible on the date of marriage. A Domestic Partner becomes eligible on the date a domestic partnership is established as set forth in the Definitions section of this booklet. A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship.

If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child, under your health benefit Plan, their coverage will become effective within 31 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.

If you or your Dependents voluntarily discontinued coverage under this Plan and later request reinstatement, you or your Dependents will be covered the earlier of 12 months from the date of request for reinstatement or at the Employer’s next Open Enrollment Period.

**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. 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, 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 and Family Deductible amounts, if applicable, are listed in the Summary of Benefits.

**LAST QUARTER CARRY OVER**

If charges for covered Services received during the last 3 months of the Calendar Year are applied to the deductible, the deductible for the next Calendar Year will be reduced by that amount.

**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.
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.**

**Note: If your Plan provides benefits for Orthodontia, a separate Calendar Year Benefit maximum applies to Orthodontic Services. See the Summary of Benefits.

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 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.

PRINCIPAL BENEFITS AND COVERAGES

The Benefits of the Plan are listed in the Summary of Benefits. 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 and oral surgeons 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

COVERED SERVICES

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

Implants (artificial materials including syn-
thetic 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, inlays or 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 surgery procedure.

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;

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 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 contracted Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;

4. charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint;

5. congenital mouth malformations or skeletal imbalances, including treatment required as the result of orthognathic surgery, orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (genitally 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, ero-
sion 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 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;

17. charges for temporary services are considered an integral part of the final dental service and will not be separately payable;

18. extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);

19. dental services performed in a hospital or any related hospital fee;

20. any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;

21. for which the Member is not legally obligated to pay, or for Services for which no charge is made;

22. treatment as a result of accidental injury including setting of fractures or dislocation;

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

24. charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;

25. charges for onlays or crowns installed as multiple abutments;

26. charges for dental appointments which are not kept, except as specified under the Summary of Benefits;

27. charges for services incident to any intentionally self-inflicted injury;

28. general anesthesia including intravenous and inhalation sedation, except when of Dental Necessity.

General anesthesia is considered dentally necessary when its use is:

a. in accordance with covered oral surgery procedures and generally accepted professional standards; and

b. not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; or

c. due to the existence of a specific medical condition;

Patient apprehension or patient anxiety will not constitute Dental Necessity.

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

29. removal of 3rd molar (wisdom) teeth other than for Dental Necessity. Dental Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericoronitis alone is not dental necessity;

30. periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;
31. any service, procedure, or supply which is received or started prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have started is defined as follows:

a. for full dentures or partial dentures: on the date the final impression is taken;

b. for fixed bridges, crowns, 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;

32. services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;

33. any and all implant services that have not been prior authorized and approved by a contracted Dental Plan Administrator if your plan provides special implant benefits.

Orthodontic Limitations and Exclusions

1. charges for services in connection with orthodontia;

2. treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;

3. treatment in progress (after banding) at inception of eligibility;

4. surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment;

5. treatment for myofunctional therapy;

6. changes in treatment necessitated by an accident;

7. treatment for Temporomandibular Joint (TMJ) disorder or dysfunction;

8. special orthodontic appliances, including but not limited to invisalign, lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;

9. replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;

10. treatment exceeding 24 months;

11. 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 24-month treatment period, the Member and not the contracted 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;

12. if the Member is reinstated after cancellation, there are no orthodontic benefits for treatment begun prior to his or her reinstatement effective date;

See the Grievance Process 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 provider may prescribe, order, recommend, or approve a service does not, in itself, make it of Dental 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 6-month period:
   a. periodic oral exam;
   b. routine prophylaxis;
   c. fluoride treatment;
d. bitewing x-rays (maximum four (4) per year);
e. 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 12 months;

2. one (1) in a 12-month period:
   a. denture (complete or partial) reline;
   b. oral cancer screening;

3. one (1) in 24 months:
   a. full mouth debridement;
   b. sealants;
   c. scaling and root planing per area;
   d. occlusal guards;
   e. diagnostic casts;
   f. full mouth series and panoramic x-rays;

4. one (1) in 36 months:
   a. mucogingival surgery per area;
   b. osseous surgery per quad;
   c. gingival flap per quad;
   d. gingivectomy per quad;
   e. gingivectomy per tooth;
   f. bone replacement grafts for periodontal purposes;
   g. guided tissue regeneration for periodontal purposes;

5. one (1) in a 5-year period:
   a. single crowns;
   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. space maintainers – only eligible for Members through age 11 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;

7. sealants – one per tooth per 2-year period through age 17 on permanent first and second molars;

8. child fluoride (including fluoride varnish) and child prophylaxis - one per 6-month period through age 17;

9. oral surgery services are limited to removal of teeth, bony protuberances and frenectomy;

10. an Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the Dentist. For example, an alternate of a partial denture will be applied when there are bilaterally missing teeth or more than three 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;

11. general or IV Sedation is covered for:
   a. 3 or more surgical extractions;
   b. 1 or more impactions;
   c. full mouth or arch alveoloplasty;
   d. surgical root recovery from sinus;
   e. medical problem contraindicates the use of local anesthesia;

   General or IV sedation is not a covered benefit for dental phobic reasons;

12. restorations, crowns, inlays and onlays - covered only if necessary to treat diseased or accidentally fractured teeth;

13. root canal treatment – one per tooth per lifetime;
14. root canal retreatment – one per tooth per lifetime;

15. pulpal therapy – through age 5 on primary anterior teeth and through age 12 on primary posterior teeth;

16. for mucogingival surgeries, one site is equal to two consecutive teeth or bounded spaces.

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 through the act or omission of another person (a “third party”), Blue Shield 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 or other available remedy to recover the reasonable costs of the Services provided to the covered Member paid by Blue Shield or a contracted Dental Plan Administrator on a fee-for-service basis.

The covered Member is required to:

1. Notify a contracted Dental Plan Administrator or Blue Shield in writing of any actual or potential claim or legal action which such covered Member anticipates bringing 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 a contracted Dental Plan Administrator or Blue Shield to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and

3. Provide a contracted Dental Plan Administrator or Blue Shield with a lien, in the amount of reasonable costs of Benefits provided, 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.

A covered Member's failure to comply with 1. through 3., above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.
REINSTATEMENT, CANCELLATION AND RESCISSION PROVISIONS

REINSTATEMENT

If you and your Dependents voluntarily cancelled coverage, you may apply for reinstatement. You or your Dependents must wait the earlier of, 12 months from the date of application to be reinstated, or at the Employer’s next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

CANCELLATION WITHOUT CAUSE

The group dental Plan may be cancelled by your Employer at any time provided written notice is given to Blue Shield of California to become effective upon receipt, or on a later date as may be specified by the notice.

CANCELLATION FOR NON-PAYMENT OF DUES - NOTICES

Blue Shield of California may cancel the group dental Plan for non-payment of Dues. If your Employer fails to pay the required Dues when due, Blue Shield of California will send your Employer a Prospective Notice of Cancellation by mail, e-mail or fax at least 15 days before any cancellation of coverage. This notice will provide information to your Employer regarding the consequences of your Employer’s failure to pay the Dues due within 15 days of the date the notice was mailed.

If payment is not received from your Employer within 15 days of the date the Prospective Notice of Cancellation is mailed, Blue Shield of California will cancel the Group Dental Service Contract at the end of that 15 day period and coverage for you and all your Dependents will end on that date. Blue Shield of California will mail your Employer a Notice Confirming Termination of Coverage. Your Employer must provide you with a copy of the Notice Confirming Termination of Coverage.

CANCELLATION/RESCISSION FOR FRAUD, OR INTENTIONAL MISREPRESENTATIONS OF MATERIAL FACT

Blue Shield of California may cancel or rescind the group contract for fraud or intentional misrepresentation of material fact by your 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.

If you are undergoing treatment for an ongoing condition and the group Contract is cancelled for any reason, including non-payment of Dues, no Benefits will be provided.

Fraud or intentional misrepresentations of material fact on an application or a health statement (if a health statement is required by the Employer) may, at the discretion of Blue Shield, result in the cancellation or rescission of the Plan. Cancellations are effective on receipt or on such later date as specified in the cancellation notice. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice prior to any rescission.

In the event the contract is rescinded or cancelled, either by Blue Shield of California or your Employer, it is your Employer's responsibility to notify you of the rescission or cancellation.

RIGHT OF CANCELLATION

If you are making any contributions toward coverage for yourself or your Dependents, you may cancel such coverage to be effective at the end of any period for which Dues have been paid.

Any Dues paid Blue Shield of California for a period extending beyond the cancellation date will be refunded to your Employer. Your Employer will be responsible to Blue Shield of California for unpaid Dues prior to the date of cancellation.

Blue Shield of California 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 provision for termination for fraud or intentional misrepresentations of material fact.

TERMINATION OF BENEFITS

Except as specifically provided under the Continuation of Group Coverage provision, if applicable, there is no right to receive benefits for services provided following termination of the group contract. The Group Dental Service Contract is issued for a 1-year period. Your Employer will notify you if your Dental coverage will not be renewed after the period of this Contract.

Coverage for you or your Dependents terminates at 12:01 a.m. Pacific Time on the earliest of these dates: (1) the date the Group Dental Service Contract is discontinued, (2) the first day of the month following the month in which the Subscriber’s employment terminates, unless a different date has been agreed to between Blue Shield and your Employer, (3) fifteen (15) days following the date of mailing of the notice to the Employer that Dues are not paid (see “Cancellation for Non-Payment of Dues – Notices”), or (4) on the first day of the month following the month in which you or your Dependents become ineligible. A spouse also becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage.
from the Subscriber. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see your Employer about possibly continuing group coverage. Also see, if applicable, the Continuation of Group Coverage provision in this booklet for information on continuation of coverage.

If your 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), your payment of Dues will keep your coverage in force for such period of time as specified in such Act(s). Your Employer is solely responsible for notifying you of the availability and duration of family leaves.

Blue Shield of California may terminate your and your Dependent’s coverage for cause immediately upon written notice to you and your Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or Blue Shield of California; see the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision;
2. Permitting use of your Subscriber identification card by someone other than yourself or your Dependents to obtain Services;
3. Obtaining or attempting to obtain Services under the Group Dental Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions;
4. Abusive or disruptive behavior which: (1) threatens the life or well-being of Blue Shield of California personnel and providers of Services, or, (2) substantially impairs the ability of Blue Shield of California to arrange for Services to the Member, or, (3) substantially impairs the ability of providers of Service to furnish Services to the Member or to other patients.

If 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 31 days following that Dependent’s effective date of coverage, Benefits under the Plan will be terminated on the 32nd day at 12:01 a.m. Pacific Time.

**PREPAYMENT FEE**

The monthly Dues for you and your Dependents 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 (called the transmittal 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 preceding 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 30 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.

**PLAN CHANGES**

The Benefits of this Plan, including but not limited to Covered Services, Deductible, and Copayment, are subject to change at any time. Blue Shield will provide at least 30 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 or oral surgeon 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 1-888-702-4171. 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:

1-888-702-4171
Dental Plan Administrator
Dental Customer Service
425 Market Street, 12th 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 and Disclosure Form.

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.

Note: You may have the right to receive continued coverage pending the outcome of your grievance. To request continued coverage during your grievance, contact Customer Service at the telephone number on your identification card.

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.

1-888-702-4171
Blue Shield of California
Dental Plan Administrator
425 Market Street, 12th Floor
San Francisco, CA 94105

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 the number listed on the last page of this booklet and use your health Plan’s grievance process before contacting the Department. Utiliz-
ing 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 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, and 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 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 Member 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 Member or other entity to or with respect to whom such payments were made.

Blue Shield may release to or obtain from any organization or Member 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 Member 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.

**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.

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 necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

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 Member receiving or providing services, including any physician, hospital, or other provider or their employees.
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. Puede leer documentos y que le envíen algunos en español. Para obtener ayuda, llame 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，請索取協助，請於您的保險卡所示的電話號碼，或撥打1-866-346-7198與我們聯絡。Chinese


무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 납득해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와 있는 연락 전화 1-866-346-7198 번으로 문의해 주십시오. Korean

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

Անվճար լեզուային ծառայություններ: Կարճ ժամանակում ձեզ կհանձնարարված լինի կանխադառնալ կամ կվերականգնանալ զբաղվածության մշակման համար տեղեկություններ, որպեսզի ձեզ կհանձնարարվի կանխադառնալ կամ կվերականգնանալ (Պ) տեղեկություն րդիկ թվով 1-866-346-7198 համարով. Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас не 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、書類を読みます。サービスをご希望の方は、カード記載の番号または1-866-346-7198までお問い合わせください。Japanese

 خدمات מיטביות😉מהזה בזרם. מיומנויות ההדרכה בمقال פורק שהת palabra. קוארא פורק. מיקום פורק מיקום פורק. פרסי

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة التدقيق للغة العربية. للحصول على المساعدة، أتصل بما على الرقم. Arabic

Blue Shield of California Customer Service Offices to Serve You
For Preadmission Review and for claims submission and information contact the appropriate
Blue Shield of California location below:

By Phone: For all counties, call Customer Service at 1-888-702-4171
By Mail: For answers to your questions, please write to the Blue Shield office listed below.

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<th>Bay Area Counties:</th>
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Please direct correspondence to*:
Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540

*Please send claims for Enhanced Dental Benefits for Pregnant Women to:
Blue Shield of California
Periodontal Coverage for Women During Pregnancy
425 Market Street, 12th Floor
San Francisco, CA 94105

If the Subscriber remains dissatisfied or if the matter involves a Non-Participating Provider, the Subscriber should contact the appropriate county Blue Shield Customer Service Department at the following number:


005735, H10455, PD7119, S05318, S05319, S05320 & S05321 (1/11)