Specialty Duo℠ Dental Plan
Blue Shield of California
Life & Health Insurance Company

Policy

Individual and Family Plan

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Specialty Duo Dental Plan

Policy for Individuals and Families

This dental Policy is issued by Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"), to the Insured Person who submitted a complete and appropriate application. In consideration of statements made in the application and timely payment of premiums, Blue Shield Life agrees to provide the Benefits of this Policy. The Benefits provided by this dental Policy do not qualify as an essential health Benefits as defined in Section 1302(b) of the Affordable Care Act.

NOTICE TO NEW INSURED PERSONS

Please read this Policy carefully. If you have questions, contact Blue Shield Life. You may surrender this Policy by delivering or mailing it within ten (10) days from the date it is received by you, to BLUE SHIELD LIFE, 50 BEALE STREET, SAN FRANCISCO, CA 94105. Immediately upon such delivery or mailing, the Policy shall be deemed void from the beginning, and premiums paid will be refunded.

IMPORTANT!

No Insured Person has the right to receive the Benefits of this Plan for services or supplies furnished following termination of coverage. Benefits of this 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 Policy. Benefits may be modified during the term of this Plan as specifically provided under the terms of this Policy 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 the modification. There is no vested right to receive the Benefits of this Plan.

IMPORTANT

If you opt to receive dental services that are not Covered Services under this Plan, a participating Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated services 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 888-271-4880 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Policy.

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Summary of Benefits and Insured Person's Copayments/Coinsurance

The following chart outlines specific dental procedures covered by the Plan and the Insured Person's Copayment responsibility for those procedures. Services are listed with the American Dental Association (ADA) Current Dental Technology procedure codes.

For Dental Care Services received from a Plan Dentist, the Insured Person will be responsible for the amount indicated under the column, "In Network Insured Person Pays:"

For dental services received from a Non-Plan Dentist, the Plan will reimburse the Insured Person up to the maximum amount listed under the column, "Out-of-Network Max. Plan Payment" and the Insured Person will be responsible for the remainder of the Dentist's billed charges.

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

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
	Diagnostic (exams and x-rays) - There is no waiting period for these procedures. [1]		
D0120	Periodic oral evaluation	You pay nothing	$16
D0140	Limited oral evaluation-problem focused	You pay nothing	$24
D0145	Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver	You pay nothing	$16
D0150	Comprehensive oral evaluation	You pay nothing	$40
D0160	Detailed and extensive oral evaluation – problem focused, be report	You pay nothing	$16
D0170	Re-evaluation – limited, problem focused (not post-operative visit)	You pay nothing	$16
D0180	Comprehensive Periodontal evaluation	You pay nothing	$48
D0190	Screening of patient	You pay nothing	$16
D0191	Assessment of a patient	You pay nothing	$16
D0210	Intraoral radiographs - complete series (including bitewings) (once every 36 months)	You pay nothing	$56
D0220	Intraoral periapical radiograph - first film	You pay nothing	$16
D0230	Intraoral periapical radiograph - each additional film	You pay nothing	$8
D0240	Intraoral occlusal radiograph	You pay nothing	$28
D0270	Bitewing radiograph - single film	You pay nothing	$14
D0272	Bitewing radiograph - two films	You pay nothing	$20
D0273	Bitewings – three films	You pay nothing	$22
D0274	Bitewing radiograph - four films	You pay nothing	$24
D0330	Panoramic film (once every 36 months)	You pay nothing	$40
D0367	Cone Beam CT capture and interpretation with field of view of both jaws with or without cranium – benefit only when placing an implant and cannot be used for Orthodontics or Periodontics.	You pay nothing	Not covered
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to	You pay nothing	$25

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
	include cytology or biopsy procedures		
D0460	Pulp vitality tests	You pay nothing	$18
D0470	Diagnostic casts	You pay nothing	$40
D0601	Caries risk assessment and documentation, with a finding of low risk[2]	You pay nothing	$16
D0602	Caries risk assessment and documentation, with a finding of moderate risk[2]	You pay nothing	$16
D0603	Caries risk assessment and documentation, with a finding of high risk[2]	You pay nothing	$16
	Preventive (Cleanings and Fluoride)- There is no waiting period for these procedures.[1]		
D1110	Prophylaxis (adult) every 6 months	You pay nothing	$48
D1120	Prophylaxis (child) every 6 months (covered through age 16)	You pay nothing	$34
D1206	Topical fluoride varnish	You pay nothing	$19
D1208	Topical application of fluoride – child(ren) under the age of 16	You pay nothing	$15
D1351	Sealant per tooth	You pay nothing	$22
D1510	Space maintainer – fixed – unilateral	You pay nothing	$148
D1515	Space maintainer – fixed – bilateral	You pay nothing	$228
D1520	Space maintainer – removable – unilateral	You pay nothing	$200
D1525	Space maintainer – removable – bilateral	You pay nothing	$228
D1550	Recementation of space maintainer	You pay nothing	$25
D1555	Removal of fixed space maintainer	You pay nothing	$25

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
	Minor Restorative (fillings) **For Waiting Period Plan Only: There is a 3-month waiting period for these procedures.**		
D2140	Amalgam - one surface, primary or permanent	$35	$28
D2150	Amalgam - two surfaces, primary or permanent	$43	$34
D2160	Amalgam - three surfaces, primary or permanent	$53	$42
D2161	Amalgam - four or more surfaces, primary or permanent	$68	$54
D2330	Resin-based composite – one surface anterior	$37	$30
D2331	Resin-based composite – two surfaces anterior	$56	$44
D2332	Resin-based composite – three surfaces anterior	$68	$54
D2335	Resin-based composite – four or more surfaces or involving incisal angle, anterior	$68	$54
D2391	Resin-based composite – one surface, posterior	$41	$32
D2392	Resin-based composite – two surfaces, posterior	$53	$41
D2393	Resin-based composite – three surfaces, posterior	$74	$58
D2394	Resin-based composite – four or more surfaces, posterior	$100	$79
	Major restorative (crowns) **For Waiting Period Plan Only: There is a 12-month waiting period for these procedures.**		
D2542	Onlay metallic – two surfaces	$142	$112
D2543	Onlay metallic – three surfaces	$158	$124
D2544	Onlay metallic – four or more surfaces	$175	$138
D2642	Onlay – porcelain / ceramic – two surfaces	$128	$101
D2643	Onlay – porcelain / ceramic – three surfaces	$150	$118
D2644	Onlay – porcelain / ceramic – four or more surfaces	$165	$130
D2710	Crown – resin based composite (indirect)	$160	$128
D2740	Crown – porcelain/ceramic substrate	$265	$212
D2750	Crown – porcelain fused to high noble metal	$320	$256
D2751	Crown – porcelain fused to predominantly base metal	$315	$252
D2752	Crown – porcelain fused to noble metal	$320	$256
D2780	Crown – ¾ cast high noble metal	$298	$238
D2781	Crown – ¾ cast predominantly base metal	$298	$238
D2782	Crown – ¾ cast noble metal	$298	$238

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
D2790	Crown – full cast high noble metal	$320	$256
D2791	Crown – full cast predominantly base metal	$320	$252
D2792	Crown – full cast noble metal	$320	$252
D2794	Crown – titanium	$320	$371
D2910	Re-cement inlay, onlay, or partial coverage restoration	$22	$17
D2915	Re-cement cast or prefabricated post and core	$22	$22
D2920	Re-cement of crown	$25	$20
D2930	Prefabricated stainless steel crown- primary tooth	$53	$42
D2931	Prefabricated stainless steel crown – permanent tooth	$59	$47
D2932	Prefabricated resin crown	$51	$41
D2934	Prefabricated esthetic coated stainless steel crown primary tooth	$53	$53
D2940	Sedative filling	$21	$16
D2950	Core buildup including any pins	$54	$43
D2951	Pin retention – per tooth, in addition to restoration	$28	$22
D2952	Post and core in addition to crown, indirectly fabricated	$86	$69
D2953	Each additional indirectly fabricated post, same tooth	$43	$33
D2954	Prefabricated post and core in addition to crown	$81	$64
D2957	Each additional prefabricated post, same tooth	$40	$31
D2980	Crown repair, by report	$50	$40
	Periodontics (gum disease) **For Waiting Period Plan Only: There is a 3 month waiting period for these procedures.**		
D4210	Gingivectomy / gingivoplasty four or more contiguous teeth or tooth bounded spaces - per quadrant	$161	$128
D4211	Gingivectomy / gingivoplasty one to three contiguous teeth or tooth bounded spaces – per quadrant	$59	$46
D4240	Gingival flap procedure including root planing four or more teeth – per quadrant	$115	$92
D4241	Gingival flap procedure including root planing one to three teeth = per quadrant	$69	$54
D4249	Clinical crown lengthening – hard tissue	$138	$110
D4260	Osseous surgery (including flap entry and closures) four or more contiguous teeth or tooth bonded spaces - per quadrant	$263	$210
D4261	Osseous surgery (including flap entry and closures) one to three contiguous teeth or tooth bonded spaces - per quadrant	$158	$124

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
D4263	Bone replacement graft each additional site in quadrant	$160	$128
D4264	Bone replacement graft each additional site in quadrant	$203	$162
D4266	Guided tissue regeneration – resorbable barrier per site	$240	$192
D4267	Guided tissue regeneration – non-resorbable barrier, per site (including membrane removal)	$240	$192
D4270	Pedicle soft tissue graft procedure	$132	$105
D4273	Subepithelial connective tissue graft procedures per tooth	$259	$207
D4276	Combination connective tissue and double pedicle graft per tooth	$132	$170
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$65	$52
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$32	$25
D4355	Full mouth debridement before comprehensive treatment	$53	$42
D4910	Periodontal maintenance procedures	$33	$35
D9951	Occlusal adjustment – limited	$50	$40
D9952	Occlusal adjustment – complete	$200	$160
	Prosthetics removable (dentures) **For Waiting Period Plan Only: There is a 12 month waiting period for these procedures.**		
D5110	Complete denture – maxillary	$388	$310
D5120	Complete denture – mandibular	$388	$310
D5130	Immediate denture – maxillary	$388	$310
D5140	Immediate denture – mandibular	$388	$310
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$375	$300
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$375	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$450	$360
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$450	$360
D5225	Maxillary partial denture - flexible base (including any clasps, rests, and teeth)	$450	$495
D5226	Mandibular partial denture - flexible base (including any clasps, rests, and teeth)	$450	$495
D5410	Adjust complete denture – maxillary	$28	$22

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
D5411	Adjust complete denture – mandibular	$28	$22
D5421	Adjust partial denture – maxillary	$28	$22
D5422	Adjust partial denture – mandibular	$28	$22
D5510	Denture repair – complete denture, broken base	$53	$42
D5520	Denture repair missing or broken teeth – complete denture (each tooth)	$53	$42
D5610	Denture repair – acrylic saddle or base	$53	$42
D5620	Denture repair – cast framework	$53	$42
D5630	Denture repair – repair or replace clasp	$69	$55
D5640	Denture repair – broken tooth - per tooth	$43	$34
D5650	Add tooth to existing partial denture	$43	$34
D5660	Add clasp to existing partial denture	$75	$60
D5670	Replace all teeth and acrylic on cast framework - maxillary	$236	$186
D5671	Replace all teeth and acrylic on cast framework - mandibular	$236	$186
D5710	Denture rebase - complete maxillary	$140	$112
D5711	Denture rebase - complete mandibular	$140	$112
D5720	Denture rebase partial maxillary	$140	$112
D5721	Denture rebase partial mandibular	$140	$112
D5730	Reline complete maxillary denture - (chairside)	$80	$64
D5731	Reline complete mandibular denture – (chairside)	$80	$64
D5740	Reline maxillary partial denture – (chairside)	$80	$64
D5741	Reline mandibular partial denture (chairside)	$80	$64
D5750	Reline complete maxillary denture – (laboratory)	$135	$108
D5751	Reline complete mandibular denture – (laboratory)	$135	$108
D5760	Reline maxillary partial denture – (laboratory)	$135	$108
D5761	Reline mandibular partial denture – (laboratory)	$135	$108
D5850	Tissue conditioning – maxillary	$33	$26
D5851	Tissue conditioning – mandibular	$33	$26
	Implants **For Waiting Period Plan Only: There is a 12 month waiting period for these procedures.**		
D6010	Surgical placement of implant body: endosteal implant	$612	Not covered
D6056	Pre-fabricated abutment-includes placement	$172	Not covered

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
D6057	Custom abutment-includes placement	$257	Not covered
D6058	Abutment supported porcelain/ceramic crown	$380	Not covered
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$370	Not covered
D6060	Abutment supported porcelain fused to metal crown (Predominately base metal)	$320	Not covered
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$343	Not covered
D6062	Abutment supported cast metal crown (high noble metal)	$354	Not covered
D6063	Abutment supported cast metal crown (predominately base metal)	$322	Not covered
D6064	Abutment supported cast metal crown (noble metal)	$343	Not covered
D6065	Implant supported porcelain/ceramic crown	$415	Not covered
D6066	Implant supported porcelain fused to metal crown	$418	Not covered
D6067	Implant supported metal crown	$405	Not covered
D6080	Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of	$75	Not covered
D6090	Repair implant supported prosthesis, by report	$211	Not covered
D6092	Recement implant/abutment supported crown	$27	Not covered
D6094	Abutment supported crown-titanium	$354	Not covered
D6095	Repair implant abutment, by report	$218	Not covered
D6100	Implant removal, by report	$228	Not covered
	Bridge abutments or pontics **For Waiting Period Plan Only; There is a 12 month waiting period for these procedures.**		
D6210	Pontic – cast high noble metal	$293	$234
D6211	Pontic – cast predominantly base metal	$293	$234
D6212	Pontic – cast noble metal	$293	$234
D6240	Pontic – porcelain fused to high noble metal	$293	$234
D6241	Pontic – porcelain fused to predominantly base metal	$293	$234
D6242	Pontic – porcelain fused to noble metal	$293	$234
D6545	Retainer- cast metal for resin bonded fixed prosthesis	$123	$98
D6608	Onlay – porcelain/ceramic, two surfaces	$128	$101
D6609	Onlay – porcelain/ceramic, three or more surfaces	$150	$118
D6610	Onlay – cast high noble metal, two surfaces	$169	$135

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
D6611	Onlay – cast high noble metal, three or more surfaces	$185	$148
D6612	Onlay – cast predominately base metal, two surfaces	$145	$116
D6613	Onlay – cast predominately base metal, three or more surfaces	$161	$128
D6614	Onlay – cast noble metal, two surfaces	$153	$122
D6615	Onlay – cast noble metal, three or more surfaces	$169	$135
D6750	Bridge retainer – crown – porcelain / fused to high noble metal	$313	$250
D6751	Bridge retainer – crown – porcelain / fused to predominantly base metal	$298	$238
D6752	Bridge retainer – crown – porcelain / fused to noble metal	$305	$244
D6780	Bridge retainer - crown – ¾ cast high noble metal	$313	$250
D6781	Bridge retainer - crown – ¾ cast predominately base metal	$313	$250
D6782	Bridge retainer - crown – ¾ cast noble metal	$313	$250
D6790	Bridge retainer – crown – full cast high noble metal	$313	$250
D6791	Bridge retainer – crown – full cast predominantly base metal	$298	$233
D6792	Bridge retainer – crown – full cast noble metal	$305	$244
D6930	Recement fixed partial denture	$38	$30
	Endodontics (root canals) **For Waiting Period Plan Only: There is a 3 month waiting period for these procedures.**		
D3110	Pulp cap (direct) excluding final restoration	$18	$14
D3120	Pulp cap (indirect) excluding final restoration	$26	$21
D3220	Pulpotomy	$33	$26
D3310	Root canal therapy - anterior tooth (excluding final restoration)	$156	$125
D3320	Root canal therapy - bicuspid tooth (excluding final restoration)	$188	$150
D3330	Root canal therapy - molar tooth (excluding final restoration)	$234	$187
D3346	Retreatment of previous root canal– anterior	$156	$145
D3347	Retreatment of previous root canal– bicuspid	$188	$180
D3348	Retreatment of previous root canal – molar	$234	$227
D3351	Apexification / Recalcification (initial treatment visit)	$73	$58
D3352	Apexification / Recalcification (interim treatment visit)	$73	$58
D3353	Apexification / Recalcification (final treatment visit)	$73	$58
D3410	Apioectomy / periradicular surgery - anterior	$200	$160
D3421	Apioectomy / periradicular surgery bicuspid – (first root)	$200	$160

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
D3425	Apioectomy / periradicular surgery – molar (first root)	$218	$174
D3426	Apioectomy / periradicular surgery – molar (each additional root)	$100	$80
D3430	Retrograde filling – per root	$101	$80
D3450	Root amputation - per root	$71	$56
D3920	Hemisection (including any root removal: not including root canal therapy)	$100	$80
	Oral Surgery (extractions) **For Waiting Period Plan Only: There is a 3 month waiting period for these procedures.**		
D7111	Extraction of coronal remnants – deciduous tooth	$20	$16
D7140	Extraction of erupted tooth or exposed root	$40	$32
D7210	Surgical removal of erupted tooth	$63	$50
D7220	Removal of impacted tooth - soft tissue	$68	$54
D7230	Removal of impacted tooth - partial bony	$104	$83
D7240	Removal of impacted tooth - complete bony, with unusual surgical complication	$113	$90
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$113	$90
D7250	Surgical removal of residual tooth roots	$55	$44
D7251	Coronectomy – intentional partial tooth removal	$98	$77
D7260	Oroantral fistula closure	$70	$56
D7286	Biopsy of oral tissue – soft [2]	$63	$50
D7287	Exfoliative cytological sample collection	$38	$30
D7288	Brush biopsy transepithelial sample collection	$32	$44
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$57	$46
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$36	$30
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$63	$50
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$42	$35
D7471	Removal of lateral exostosis maxilla or mandible	$88	$70
D7472	Removal of torus palatinus	$88	$70
D7473	Removal of torus mandibularis	$88	$70

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
D7510	Incision & drainage of abscess – intraoral soft tissue	$38	$30
D7511	Incision & drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple facial spaces)	$48	$65
D7550	Partial ostectomy / equestrectomy for removal of non-vital bone	$100	$80
D7960	Frenectomy / Frenectomy – separate procedure	$88	$70
D7963	Frenuloplasty	$88	$122
D7970	Excision of hyperplastic tissue – per arch [3]	$100	$80
D7971	Excision of pericoronal gingival [3]	$43	$34
	Adjunctive General Services [4]- There is no waiting period for these procedures.		
D9110	Palliative (emergency) treatment of dental pain – minor procedure[4]	$25	$20
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	You pay nothing	Not covered
D9215	Local anesthesia in conjunction with outpatient surgical procedures	You pay nothing	Not covered
D9220	General anesthesia – first 30 minutes	$23	$58
D9221	General anesthesia – each additional 15 minutes	$30	$24
D9230	Analgesia (per half hour)	$15	$12
D9241	IV sedation – first 30 minutes	$98	$78
D9242	IV sedation – each additional 15 minutes	$30	$24
D9910	Application of desensitizing medicament	$10	$8
D9940	Occlusal guards, by report	$113	$90
D9942	Repair and/or reline of occlusal guard	$34	$34
D9310	Specialist – consultation (as necessary)	$30	$24
	Other-There is no waiting period for these procedures.		
	Sterilization surcharge [5]	You pay nothing	Not covered
	Additional periodontal coverage and maintenance for women during pregnancy- There is no waiting period for these procedures.		
D1110 – 1	Prophylaxis (adult) every 6 months	You pay nothing	100% of Charge
D4341 – 1	Periodontal scaling and root planing four or more teeth – per quadrant	You pay nothing	100% of Charge
D4342 – 1	Periodontal scaling and root planing – one to three teeth - per quadrant	You pay nothing	100% of Charge
D4910 – 1	Periodontal maintenance	You pay nothing	100% of Charge

ADA CODE	PROCEDURE	In Network Insured Pays:	Out of Network Max. Plan Payment:
	Orthodontics [7, 8, 9] **Orthodontic treatment to correct malocclusion, limited to one continuous two-year course of treatment. For Waiting Period Plan Only: There is a 12-month waiting period for these procedures**		
D8080	Comprehensive Orthodontic treatment of the adolescent dentition [7]	$2,350	Not covered
D8090	Comprehensive Orthodontic treatment of the adult dentition [7]	$2,650	Not covered

Footnotes

1 Diagnostic and preventive services do not apply towards the maximum Calendar Year payment. If your plan has enhanced dental Benefits for pregnant women, those services do not apply towards the maximum Calendar Year payment either.

2 Caries risk management - CAMBRA (Caries Management By Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; "medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to 2 fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website). Charges for saliva and bacterial testing when caries management procedures D0601, D0602, and D0603 are performed are not covered.

3 The Insured Person pays lab fees for biopsies and excisions.

4 When the treatment is a covered procedure and treatment for dental pain is also required, there are separate Copayments for the procedure and the pain treatment.

5 Emergency oral exam including Palliative Treatment (if treatment includes a listed procedure regular Copayment applies.

6 No Benefits are provided if these Covered Services are performed by a Non-Participating Dentist.

7 In order to be covered Orthodontic treatment; must be received in one continuous course of treatment; must be received in consecutive months; and must not exceed 24 consecutive months except for treatment prior approved by Blue Shield as Dentally Necessary.

8 Full case fee includes consultation, treatment plan, tooth movement, and retention. Orthodontist may charge Insured Persons separately for records, limited to $250 per case.

9 The Orthodontic Benefit is subject to all Plan limitations.

Introduction to the Specialty Duo Dental Plan

The Specialty Duo (Dental + Vision) Plan package consists of a dental plan and a vision plan which is offered at a package rate. This Policy describes the Benefits of the Specialty Duo Dental Plan, the dental plan in the Specialty Duo (Dental + Vision) package.

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.

Before Obtaining Dental Care 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 Dental Plan Administrator at 888-679-8928. You may also access a list of Participating Dentists through Blue Shield Life's internet site located at http://www.blueshieldca.com. You are also responsible for following the precertification of Dental Benefits Program that includes obtaining or assuring that the Dentist obtains precertification of Benefits.

Note: A Dental Plan Administrator will respond to all requests for precertification and prior Authorization within five (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 an Insured Person or when the Insured Person is experiencing severe pain, a Dental Plan Administrator will respond within 72 hours from receipt of the request.

Failure to meet these responsibilities may result in denial of Benefits. However, by following the precertification process both you and your Dentist will know in advance which services are covered and that Benefits are payable.

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

Choice of Dentists

The Specialty Duo Dental Plan is specifically designed for you to use Participating Dentists. Participating Dentists agree to accept a Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Copayment/Coinsurance, as payment in full for Covered Services. This is not true of Non-Participating Dentists.

Participating Dentists submit claims for payment after Dental Care Services have been rendered. Payments for these claims go directly to the Participating Dentist. You or your Non-Participating Dentists submit claims for reimbursement after services have been rendered. If you receive Dental Care Services from Non-Participating Dentists, you have the option of having payments sent directly to the Non-Participating Dentist or sent directly to you. A Dental Plan Administrator will notify you of its determination within 60 days after receipt of the claim.

Participating Dentists do not receive financial incentives or bonuses from Blue Shield Life.

You may access a Directory of Participating Dentists through Blue Shield Life's Internet site located at http://www.blueshieldca.com. The names of Participating Dentists in your area may also be obtained by contacting a Dental Plan Administrator at 888-679-8928.

Precertification of Dental Benefits

Before any course of treatment expected to cost more than $250 is started, you should obtain precertification of Benefits. Your Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic x-rays to a Dental Plan Administrator. A 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 Dental Plan Administrator for payment determination. A 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 (2) or more professionally recognized procedures for treatment of a dental condition, this Plan will in most cases provide Benefits based on the most cost-effective procedure. The Benefits provided under this plan are based on these considerations but you and your Dentist make the final decision regarding treatment.

Failure to obtain precertification of Benefits may result in a denial of Benefits. If the precertification process is not followed, a 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 Dental Plan Administrator. If you and your Dentist decide on a more costly procedure, service, or material than a 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 Dental Plan Administrator reserves the right to use the services of dental consultants in the precertification review.

Example:

1. If a crown is placed on a tooth which can be restored by a filling, Benefits will be based on the filling;

2. If a semi-precision or precision partial denture is inserted, Benefits may be based on a conventional clasp partial denture.

3. If a bridge is placed and the patient has multiple un-restored missing teeth, Benefits will be based on a partial denture.

Participating Dentists

When you receive Covered Services from a Participating Dentist, you will be responsible for a fixed Copayment/Coinsurance as outlined under the section entitled Summary of Benefits and Insured Person's Copayments/Coinsurance. Participating Dentists will file claims on your behalf.

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 will be paid directly by the Plan, and have agreed to accept a Dental Plan Administrator's payment, plus your payment of any applicable Deductible or Copayment/Coinsurance, as payment in full for Covered Services.

If the Insured Person 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 Dental Plan Administrator as payment in full, but may collect from the Insured Person the difference, if any, between the fees paid by a Dental Plan Administrator and the amount collected by the covered Insured Person for these services.

Non-Participating Dentists
When you receive Covered Services from a Non-Participating Dentist, you will be reimbursed up to a specified maximum amount as outlined in the section entitled Summary of Benefits and Insured Person's Copayments/Coinsurance. You will be responsible for the remainder of the Dentist's billed charges. You should discuss this beforehand with your Dentist if he is not a Participating Dentist. Any difference between a Dental Plan Administrator's or Blue Shield Life's payment and the Non-Participating Dentist's charges are your responsibility. Insured Persons are expected to follow the billing procedures of the dental office.
If your receive Covered Services from a Non-Participating Dentist, either you or your Dentist may file a claim using the dental claim form which may be obtained by calling Dental Insured Person services at:

888-679-8928

Only claims for Benefits for enhanced dental services for pregnant women should be sent to:

Blue Shield Life
Dental Plan Administrator
Coverage for Women during Pregnancy
425 Market Street, 15th Floor
San Francisco, CA 94105

Claims for all other Covered Services rendered by Non-Participating Dentists, should be sent to:

Blue Shield Life
P. O. Box 272590
Chico, CA 95927-2590

Continuity of Care by a Terminated Dentist
Insured Persons 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 Dentist 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 Dentist who is leaving a 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 Dentist.

Financial Responsibility for Continuity of Care Services
If an Insured Person is entitled to receive Covered Services from a terminated Dentist under the preceding Continuity of Care provision, the responsibility of the Insured Person to that Dentist for services rendered under the Continuity of Care provision shall be no greater than for the same Covered Services rendered by a Participating Dentist in the same geographic area.

Premiums
Monthly premiums are as stated in the Appendix. Blue Shield Life offers a variety of options and methods by which you may pay your premiums. Please call Customer Service at 1-800-431-2809 to discuss these options or visit the Blue Shield Life internet site at http://www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield Life
P.O. Box 51827
Los Angeles, CA 90051-6127

Additional premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield Life a tax or license fee, which is calculated upon, base premiums or Blue Shield Life's gross receipts or any portion of either. Premiums may increase from time to time as determined by Blue Shield Life. You will receive sixty (60) days written notice of any changes in the monthly premiums for this Plan.

Conditions of Coverage

Eligibility and Enrollment

1. To enroll and continue enrollment, an Insured Person must meet all of the eligibility requirements of the Plan.

2. Enrollment of Insured Persons or Dependents is not effective until Blue Shield Life approves an application and accepts the applicable premiums. Only Blue Shield Life can approve applications.

3. An applicant, upon completion and approval by Blue Shield Life of the application, is entitled to the Benefits of this Policy upon the effective date.

   By completing an application, the Insured Person and/or Dependent(s) agrees to cooperate with Blue Shield Life by providing, or providing access to, documents and other information that the Plan may request to corroborate the information for coverage. If the Insured Person and/or Dependent(s) fail or refuse to provide these documents or information to Blue Shield Life, coverage under this Plan may be cancelled.

4. The effective date of the Benefits of a newborn child will be the date of birth if the Insured Person contact Blue Shield Life at the Customer Service telephone number listed at the back of this booklet to have the newborn child added to this Policy as a Dependent. Such request must be made within 31 days of the newborn child's date of birth. If a request to add the child as a Dependent is not made within 31 days of birth, the coverage for that child shall terminate on the 31st date at 11:59 P.M. Pacific Time.

   If the Insured Person wishes to add a newborn child as a Dependent 32 or more days after birth, coverage will not be retroactive and there will be a gap in coverage. See Paragraph 6 below.

5. The effective date of Benefits for an adopted child will be the date the Insured Person or spouse or Domestic Partner has the right to control the child's health care, if the Insured Person request the child be added to this Policy as a Dependent. Such request must be made within 31 days of the date the Insured Person, spouse, or Domestic Partner has the right to control the child's health care. If a request to add the child as a Dependent is not made within 31 days of the date the Insured Person, spouse, or Domestic Partner has the right to control the child's health care, the coverage for that child shall terminate on the 31st day at 11:59 P.M. Pacific Time.

   To add a child placed for adoption to this Policy as a Dependent, the Insured Person must contact Blue Shield Life at the Customer Service telephone number listed at the back of this booklet. The Customer Service Department will advice the Insured Person of the exact process for adding a child placed for adoption as a Dependent, including, but not limited to, the necessary documentation and how the documentation shall be submitted to Blue Shield Life. Enrollment requests for an adopted child must be accompanied by evidence of the Insured Person's or spouse's or Domestic Partner's right to control the child's health care, which includes a facility minor release report, a medical authorization form, or a relinquishment form.

   If the Insured Person wishes to add a child placed for adoption as a Dependent 32 or more days after the date the Insured Person, spouse, or Domestic Partner has the right to control the child's health care, coverage will not be retroactive and here will be a gap in coverage. See Paragraph 6 below. Blue Shield Life will require the submission of a completed application, and the child will be subject to medical underwriting. This may result in the child being declined coverage by Blue Shield Life.

6. If a court has ordered that you provide coverage for your spouse or Domestic Partner under your Plan, their coverage will become effective within 31 days of presentation of a court order.

7. The Subscriber can also add a Dependent under the age of 26 as long as they apply during a period no longer than 63 days after any event listed below:

   a. Losing Dependent coverage due to:
   (i) The termination or change in employment status of this Dependent or the person through whom this Dependent was covered; or

   (ii). The cessation of an employer's contribution toward an employee or Dependent's coverage; or

   (iii) The death of the person through whom this Dependent was covered as a Dependent; or

   (iv) Legal separation or divorce; or

   b. Loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program or the Medi-Cal Program; or

   c. Adoption of the child; or

d. The child became a Resident of California during a month that was not the child's birth month; or

e. The child is born as a Resident of California and did not enroll in the month of birth; or

f. The child is mandated to be covered pursuant to a valid state or federal court order (presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, of Section 3751.5 of the California Family Code).

Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the Premium for the same coverage may be higher than the Premium you pay now.

Limitation on Enrollment

1. Insured Persons must be Residents of California. Upon change of residence to another jurisdiction, this Policy will terminate.

2. Dependent Benefits shall be discontinued as of the following, except as specifically set forth in the definition of Dependent in the section entitled Definitions:

   a. The date the Dependent child attains age 26, unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent;

   b. The date the Dependent spouse or Domestic Partner enters a final decree of divorce, annulment, or dissolution, or termination of domestic partnership or marriage from the Subscriber.

3. If the Subscriber seeks to add a Dependent under age 26 to the Policy other than a Dependent described in the paragraphs 3., 4., 5., or 6. of the section entitled "Enrollment", this will result in Blue Shield Life recalculation or reassigning the appropriate premiums based on underwriting review of the Dependent.

Duration of the Policy

This Policy shall be renewed upon receipt of prepaid premiums. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in premiums or Benefits, including but not limited to Covered Services, Deductible, Copayment, Coinsurance, and Calendar Year maximum payment, are effective after 60 days notice to the Subscriber's address of record with Blue Shield Life.

Renewal of the Policy

Blue Shield Life shall renew this Policy, except under the following conditions:

1. Non-payment of premiums;

2. Fraud, misrepresentation or omission of material fact;

3. Termination of plan type by Blue Shield Life;

4. Subscriber moves out of California or the Subscriber is no longer a Resident of California;

5. If a bona fide association arranged for the Subscriber's coverage under this Policy, when that Subscriber's membership in the association ceases.

Termination / Reinstatement of the Policy

This Policy may be terminated or cancelled as follows:

1. Termination by the Subscriber:
   A Subscriber desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.

2. Termination by Blue Shield Life through cancellation:

   Blue Shield Life may cancel this Policy with five (5) days written notice for the following reasons:

   a. Fraud or deception in obtaining, or attempting to obtain, Benefits under this Policy; or

   b. Knowingly permitting fraud or deception by another person in connection with this Policy, such as, without limitation, permitting someone to seek Benefits under this Policy, or improperly seeking payment from Blue Shield Life for Benefits provided.

   Cancellation of the Policy under this section will terminate the Policy five (5) days following the date that written notice of termination is mailed to the Subscriber. It is not retroactive to the original effective date of the Policy.

3. Termination by Blue Shield Life if Subscriber moves out of California:

   Blue Shield Life may cancel this Policy upon thirty (30) days written notice if the Subscriber moves out of California.

   Within 30 days of the notice of cancellation under sections 2 or 3 above, Blue Shield Life shall refund the prepaid premiums, if any, that Blue Shield Life determines will not have been earned as of the termination date. Blue Shield Life reserves the right to subtract from any such premiums refund any amounts paid by Blue Shield Life for Benefits paid or payable by Blue Shield Life prior to the termination date.

4. Termination by Blue Shield Life due to withdrawal of the Policy from the market:

   Blue Shield Life may terminate this Policy together with all like Policies to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll in any other individual dental Policy without regard to health status-related factors.

5. Cancellation of the Policy for non-payment of premiums:

   Blue Shield Life may cancel this Policy for failure to pay the required premiums, when due. If the Policy is being cancelled because you failed to pay the required premiums when due, then coverage will end 30 days after the date for which these premiums are due. You will be liable for all premiums accrued while this Policy continues in force including those accrued during this 30 day grace period.

   Within five (5) business days of canceling Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

   a. That the Policy has been cancelled, and the reasons for cancellation; and

   b. The specific date and time when all coverage under this Policy ended.

6. Reinstatement of the Policy after Termination for non-payment:

   If the Policy is cancelled for non-payment of premiums the Plan will permit reinstatement of the Policy or coverage twice during any twelve-month period, without a change in premiums and without consideration of your medical condition, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

   If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Plan may impose different premiums and consider your medical condition.

Calendar Year Deductible
There is a Calendar Year Deductible of $50 that applies to all Covered Services and supplies furnished by Participating and Non-Participating Dentists [1]. It is the amount that you must pay out of pocket before Benefits will be provided for Covered Services. This Deductible applies each Calendar Year. This Deductible applies separately to each covered Insured Person, each Calendar Year.

[1] The Calendar Year Deductible does not apply to those Dental Care Services considered by Blue Shield Life to be diagnostic or preventive. Services that are considered diagnostic or preventive by Blue Shield Life are listed in section entitled the "Summary of Benefits and Insured Person's Copayments".

Calendar Year Maximum Payment
Your Plan pays up to a maximum of $1,000 per Insured Person, per Calendar Year for Covered Services and supplies provided by Participating Dentists.

Your Plan pays a maximum of $500 per Insured Person, per Calendar Year for Covered Services and supplies provided by Non-Participating Dentists.

The maximum payment per Insured Person, per Calendar Year for Covered Services and supplies provided by any combination of Participating and Non-Participating Dentists is $1,000.

No Benefits in excess of this amount will be provided to or on behalf of any Insured Person.

Covered Services and Supplies
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.

These Benefits are subject to the general limitations and exclusions of the plan. Payments are subject to the dental benefit deductible and to the Copayment/Coinsurance amounts indicated in the section entitled "Summary of Benefits and Insured Person Copayments/Coinsurance".

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.

Diagnostic and Preventive Services
Diagnostic and preventive services provided by Participating Dentists will be covered at 100%, subject to the limitations in the General Limitations section.

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 the section entitled Diagnostic and preventive services; and

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, coverage is available under the section entitled "Endodontics, Oral Surgery, Periodontics, and restorative services".

Basic Services

Endodontics, Oral Surgery, Periodontics and Restorative Services
These services are covered after 90 days of continuous coverage under the plan.

Refer to the section entitled "Summary of Benefits and Insured Person Copayments/Coinsurance" for fixed Copayments, Coinsurance, and maximum reimbursement amounts.

Anesthesia — General, intravenous, or inhalation sedation is only a covered Benefit when provided in conjunction with a covered oral surgical procedure. See General Limitations and Exclusions section for more details.

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 postoperative 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; Amalgam restorations; synthetic restorations (i.e. silicate cement filling, porcelain filling, plastic filling and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material. Onlays, crowns (other than stainless steel); veneers and other laboratory produced restorations and bridges are excluded.

Minor Restorative Services
Amalgam restorations; synthetic restorations (i.e. plastic filling, and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material, onlays, crowns (other than stainless steel); veneers and other laboratory produced restorations. And bridges are excluded from minor restorative services.

Major Services
These services are covered after twelve months of continuous coverage under the plan.

Refer to the section entitled "Summary of Benefits and Insured Person Copayments/Coinsurance" for fixed Copayments, Coinsurance, and maximum reimbursement amounts.

Implants – Single tooth implant is offered for initial replacement of any missing single tooth except second and third molars and lower anterior teeth. Failed implant, second and third molar and lower anterior tooth replacement is not included. Benefits include the surgical implant placement, bone grafting to the site (if required), abutment that screws into the implant body (if one is utilized) and the prosthetic crown that is supported by the surgical implant. Benefits are provided for the maintenance, repair and removal of the implant.

You must be 21 or older to be eligible for dental implant Benefits due to continued growth and development of the mid face and jaws. If there are bilaterally missing teeth and/or or non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Insured Person will be given an alternate Benefit of a partial denture. If there are more than three teeth missing and/or more than three non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Insured Person will be given an alternate Benefit of a partial denture. If an Insured Person elects a different procedure, payment will be based on the partial denture Benefit.

Cone Beam (CT) (D0367) is a benefit only when placing an implant. This procedure cannot be used for Orthodontics or periodontics. This is a once in a lifetime benefit and is limited to projection of upper and lower jaws only.

Prosthetics — Bridges, dentures, partials and relining or rebasing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stayplate, and special tissue conditioning per denture. No replacement of complete or partial dentures, implants, fixed bridgework or crowns previously covered by the Plan due to loss or theft within sixty (60) months after initial or supplemental placement. This also applies to the damage of any prostheses that is not directly related to faulty lab work. "Prostheses" include retainers, habit appliances and any fixed or removable interceptive Orthodontic appliances as well as fixed and removable bridgework.

No replacement of dentures (complete or partial), implants, crowns or fixed bridgework due to provider error. The provider is financially responsible for comparable replacement. If replacement is warranted because of an action by, or the non-compliance of, the patient, that patient is financially liable for replacement of the prosthesis (this includes decay or periodontal disease directly related to patient non-compliance). The

Plan will pay for a replacement in this instance after the sixty (60) months waiting period from initial placement has elapsed.

Denture relines (either complete or partial conventional dentures) within six (6) months after insertion of the prosthesis. This service is covered once every twelve months following initial insertion or reline. In the case of immediate full or partial dentures, the final reline must be performed no sooner than eight weeks after tooth extractions and denture insertion. Chair-side tissue conditioners can be used for temporary relief of discomfort and/or to increase retention and be considered Palliative Treatment. Relines for immediate full and partial dentures will not be covered within two (2) weeks of tooth extraction and prosthesis insertion. One reline for each prosthesis is included in the immediate denture fee between two (2) and six (6) months following insertion.

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); 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 five (5) years old. Repair or re-cementing of onlays and crowns, is covered for six (6) months after installation.

Orthodontics — Dental Care Services specifically related to necessary services for the treatment for malocclusion and the proper alignment of teeth are covered, if rendered by a Dental Provider. Orthodontic treatment is limited to one full case during the lifetime of the Insured Person and consists of 24 continuous months of usual and customary Orthodontic care.

The Insured Person must remain eligible throughout the entire course of treatment to receive the full benefit.

The member Copayments listed in the Schedule of Benefits apply to Orthodontic treatment that does not include Invisalign® system or lingual, invisible, sapphire or clear braces. Member must pay the difference for any other types of orthodontia except ceramic braces. Ceramic braces are not covered.

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. Charges for services in connection with any treatment to the gums for tumors, cysts and neoplasms;
3. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers compensation law, occupational disease law or similar legislation. However, if a Dental Plan Administrator or Blue Shield 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 Dental Plan Administrator or Blue Shield Life for the treatment of such injury or disease;
4. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint ;
5. Congenital mouth malformations or skeletal imbalances, including treatment required as the result of orthognathic surgery, Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
6. All prescription and non-prescription drugs;
7. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
8. Services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in nature or which do not have uniform professional endorsement;
9. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;
10. Cosmetic procedures including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures;
11. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been either lost or stolen within five (5) years of its installation;
12. Myofunctional therapy; biofeedback procedures; athletic mouth-guards; precision or semi-precision attachments; denture duplication; treatment of jaw fractures;
13. Orthognathic surgery, including but not limited to, os-

teotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;

14. Charges for services in connection with orthodontia
15. Alloplastic bone grafting materials;
16. Bone grafting done for socket preservation after tooth extraction (unless your plan provides special implant Benefits. Please see the Summary of Benefits to determine if you have implant Benefits.);
17. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
18. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
19. Any procedure not performed in a dental office setting;
20. Dental services performed in a hospital or any related hospital fee;
21. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a Dental Plan Administrator and its dental consultants;
22. Services for which the Insured Person is not legally obligated to pay, or for services for which no charge is made;
23. Treatment as a result of Accidental Injury including setting of fractures or dislocation;);
24. Treatment for which payment is made by any governmental agency, including any foreign government;
25. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
26. Charges for onlays or crowns installed as multiple abutments;
27. Any inlay restoration;
28. Charges for dental appointments which are not kept, except as specified under the Summary of Benefits;
29. Charges for services incident to any intentionally self-inflicted injury;
30. General anesthesia including intravenous and inhalation sedation, except when Dentally Necessary.

    General anesthesia is considered Dentally Necessary when its use is:

    a) In accordance with generally accepted professional standards; and

    b) Not furnished primarily for the convenience of the patient, the attending Dentist, or other provider;

    c) Due to the existence of a specific medical condition.

    Patient apprehension or patient anxiety will not constitute Dental Necessity.

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

31. Removal of 3rd molar (wisdom) teeth other than for Dental Necessity. Dental Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not Dentally Necessary.
32. 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;
33. 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.

34. For services provided by an individual or entity that is not licensed or certified by the state to provide Dental Care Services, or is not operating within the scope of such license or certification, except as specifically stated herein;
35. Charges for saliva and bacterial testing when caries management procedures D0601, D0602, and D0603 are performed;
36. Any and all implant services that have not received prior Authorization and approval by a Dental Plan Administrator if your plan provides special implant Benefits. Implants that are used as an abutment, double abutment, or bone anchor to support or hold a fixed bridge, orthodontic appliance, removable prosthesis, or oral-maxillofacial prosthesis are not covered.

Orthodontic Limitations & Exclusions

1. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
2. Charges for services in connection with orthodontia when rendered by a Non-Plan Provider;
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 TMJ (Temporomandibular Joint) disorder or dysfunction;
8. Special Orthodontic appliances, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be Cosmetic;
9. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
10. Treatment exceeding twenty-four (24) months except for treatment prior approved by Blue Shield Life as Dentally Necessary;
11. In the event of an Insured Person's loss of coverage for any reason, if at the time of loss of coverage the Insured is still receiving Orthodontic treatment during the 24 month treatment period, the Insured and not a 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 Insured is reinstated after Cancellation, there are no Orthodontic Benefits for treatment begun prior to his or her reinstatement effective date:
13. There is a twelve (12) month waiting period before beginning Orthodontic treatment.
14. If the member elects to use the Invisalign® system, Member pays both the Member cost for "standard" Orthodontic system of brackets and wire, and the additional costs for the Invisalign® system beyond what Blue Shield Life and Member would pay for "standard" Orthodontic system of brackets and wires. See the Grievance Process for information on filing a grievance and your right to seek assistance from the Department of Insurance.

Dental Necessity Exclusion

All services must be of Dentally Necessary. The fact that a Dentist or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Dental Necessity.

Alternate Benefits Provision

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the 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 six (6) months :
   a) Periodic oral exam;
   b) Routine prophylaxis;
   c) Fluoride treatment;
   d) Bitewing x-rays (two sets of single films or one set of two films);
   e) Recementations if the crown was provided by other than the original Dentist; not eligible if the Dentist is doing the recementation of a service he/she provided within twelve (12) months; and
   f) Periodontal maintenance;
2. One (1) in twelve (12) months:
   a) Denture (complete and partial) relines;
   b) Oral cancer screening;
   c) Bitewing x-rays, maximum four (4) per occurrence; and
   d) Topical fluoride varnish (coverage limited to three (3) applications, when used as a therapeutic application in patients with a moderate-to-high carries risk);
3. One in twenty-four (24) months:
   a) Gingival flap surgery per quad;
   b) Sealants;
   c) Diagnostic casts; and
   d) Occlusal guards;
4. One (1) in thirty-six (36) months:
   a) Mucogingival surgery per area;
   b) Osseous surgery per quad;
   c) Full mouth debridement;
   d) Gingivectomy per quad;
   e) Gingivectomy per tooth;
   f) Bone replacement grafts for periodontal purposes;
   g) Guided tissue regeneration for periodontal purposes
   h) Full mouth series and panoramic x-rays;
   i) Intraoral x-rays – complete series including bitewings;
   j) Panoramic film;
5. One (1) in five (5) years:
   a) Single crowns and onlays;
   b) Single post and core buildups;

c) Crown buildup including pins;

d) Prefabricated post and core;

e) Cast post and core in addition to crown;

f) Complete dentures;

g) Partial dentures;

h) Fixed partial denture (bridge) pontics;

i) Fixed partial denture (bridge) abutments;

j) Abutment post and core buildups;

6. Space maintainers – only eligible for Insured Persons through age fifteen 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 two-year period through age eleven (11) on permanent first and second molars;

8. Child fluoride (including fluoride varnish) and child prophylaxis – one per six (6) month period through age sixteen;

9. Topical fluoride varnish; therapeutic application for moderate to high caries risk patients – three in a twelve month period;

10. Oral Surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy and crown lengthening;

11. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the Dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the Insured Person to the less costly treatment. However, if the Insured and the Dentist choose the more expensive treatment, the Insured is responsible for the additional charges beyond those allowed for the ABP;

12. General, IV or inhalation sedation is covered for:

a) 3 or more surgical extractions;

b) Any number of Dentally Necessary impactions;

c) Full mouth or arch alveoloplasty;

d) Surgical root recovery from sinus;

e) Medical problem contraindicates local anesthesia;

f) Children under the age of seven (7) years old.

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

Restorations, crowns, 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. For mucogingival surgeries, one (1) site is equal to two (2) consecutive teeth or bonded spaces.

16. Scaling and root planing – covered once for each of the four quadrants of the mouth in a 24 month period. Scaling and root planing is limited to two quadrants of the mouth per visit.

17. Cone Beam CT (D0367) is a benefit only when placing an implant. This procedure cannot be used for Orthodontics or Periodontics. This is a once in a lifetime benefit and is limited to projection of upper and lower jaws only.

18. You must be twenty-one (21) years of age or older to be eligible for dental implant Benefits due to continued growth and development of the mid face and jaws. If there are bilaterally missing teeth and/or non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Insured Person will be given an alternate Benefit of a partial denture. If there are more than three teeth missing and/or more than three non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Insured Person will be given an alternate benefit of a partial denture. If a Member elects a different procedure, payment will be based on the partial denture Benefit.

Claims Review

The Plan reserves the right to review all claims to determine if any exclusions or limitations apply, and may use the services of Dentist consultants, peer review committees of professional societies, and other consultants.

Reductions – Third-Party Liability

If an Insured is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield Life or a Dental Plan Administrator shall, with respect to services required as a result of that injury, provide the Benefits of this Policy and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield Life paid for services provided to the Insured Person paid by Blue Shield Life or a Dental Plan Administrator on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Insured Person, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

Blue Shield Life's right to restitution, reimbursement or other available remedy is against any recovery the Insured Person receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured

motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Insured Person has been "made whole" by the Recovery. Blue Shield Life's right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due Blue Shield Life for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The Insured Person is required to:

1. Notify Blue Shield Life or a Dental Plan Administrator in writing of any actual or potential claim or legal action which such Insured Person expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than thirty 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate and execute any forms or documents needed to enable Blue Shield Life to enforce its right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse Blue Shield Life for Benefits paid by Blue Shield Life for any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide a lien calculated in accordance with California Civil Code Section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield Life and a Dental Plan Administrator, in writing, within ten (10) days after any Recovery has been obtained.

An Insured Person's failure to comply with 1 through 5, above, shall not in any way, act as a waiver, release, or relinquishment of the rights of the Plan.

Further, if the Insured Person receives services from a Blue Shield Life contracted hospital for such injuries or illness, the hospital has the right to collect from the Insured Person the difference between the amount paid by Blue Shield Life and the hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Insured Person for dental expenses. The hospital's right to collect shall be in accordance with California Civil Code section 3045.1 Dental Plan Administrator.

An Insured Person's failure to comply with 1. through 5. above, shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan.

Further, if the Insured Person receives services from a Blue Shield Life contracted hospital for such injuries or illness, the hospital has the right to collect from the Insured Person the difference between the amount paid by Blue Shield Life and the hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Insured Person for dental expenses. The hospital's right to collect shall be in accordance with California Civil Code section 3045.1.

Other Provisions

Assignability
The coverage and Benefits of this Plan are assignable to Participating and Non-Participating Dentists.

Possession of a Blue Shield Life identification card confers no right to services or other Benefits of this Policy. To be entitled to Covered Services, the Insured Person must be a Subscriber who has maintained enrollment under the terms of this Policy.

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 back of this booklet or 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 Number:
888-266-8080

E-mail Address:
BlueShieldca_Privacy@blueshieldca.com

Access to Information
Blue Shield Life may need information from medical providers, from other carriers or other entities, or from you, in order to administer Benefits and eligibility provisions of this Policy. You agree that any provider or entity can disclose to Blue Shield Life that information that is reasonably needed by Blue Shield Life. You agree to assist Blue Shield Life in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield Life with information in your possession. Failure to assist Blue Shield Life 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 Life will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Independent Contractors
Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions of any person providing services, including any Dentist or their employees.

Entire Policy: Changes
This Policy, including the appendices, constitutes the entire agreement between parties. Any statement made by an Insured Person shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Policy shall be valid unless approved by a corporate officer of Blue Shield Life and a written endorsement issued. No agent has authority to change this Policy or to waive any of its provisions.

Benefits, such as Covered Services, Calendar Year Benefits, Deductible, Copayment, Coinsurance, maximum per Insured Person Calendar Year Copayment/Coinsurance responsibility, or maximum per Insured Person and family Calendar Year Copayment/Coinsurance responsibility amounts are subject to change at any time. Blue Shield Life will provide at least 60 days written notice of any such change.

Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain Benefits.

Time Limit on Certain Defenses
After an Insured Person has been covered under this Policy for two (2) consecutive years, Blue Shield Life will not use any omission, misrepresentation, or inaccuracy made by the applicant in an individual application to limit, cancel or rescind the Policy, deny a claim, or reduce premiums.

Grace Period
After payment of the first Premium, the Subscriber is entitled to a grace period of 30 days for the payment of any Premium due. During this grace period, the Policy will remain in force. However, the Subscriber will be liable for payment of premiums accruing during the period the Policy continues in force.

Reinstatement, Cancellation and Rescission Provisions

Reinstatement

If you and your Dependents voluntarily cancelled coverage, you may apply for reinstatement in the same Plan. If you submit a reinstatement request in writing within sixty (60) days of termination and your request is approved, your reinstatement date will be the same day your Plan was cancelled so there will be no lapse in coverage. However, you will be responsible for paying any past due Premiums for the time between your voluntary cancellation and the date of your reinstatement approval. If you do not submit a reinstatement request in writing within sixty (60) days of termination, you must wait six (6) months before you will be reinstated. Reinstatement will be effective on the first of the next month following approval.

Cancellation Without Cause

The Plan may be cancelled by the Subscriber at any time provided 5 days written notice is given to Blue Shield Life 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 Life may cancel the Dental Service Plan for nonpayment of Dues. If the Subscriber fails to pay the required Dues when due, coverage will end 30 days after the date for which Dues are due. You will be liable for all Dues accrued while this Plan continues in force including those accrued during the 30 day grace period. Blue Shield Life will mail you a Notice Confirming Termination of Coverage.

Cancellation/Rescission for Fraud, or Intentional Misrepresentations of Material Fact

Blue Shield Life may cancel or rescind the Dental Service Plan for fraud or intentional misrepresentation of material fact by the Subscriber, Dependent, or their representative or with respect to coverage of Subscriber or Dependents, for fraud or intentional misrepresentation of material fact.

If you are undergoing treatment for an ongoing condition and the Dental Service Plan 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 may, at the discretion of Blue Shield Life, 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 Life will provide written notice prior to any rescission.

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

Right of Cancellation

You may cancel coverage to be effective at the end of any period for which Dues have been paid.

Any Dues paid to Blue Shield Life for a period extending beyond the cancellation date will be refunded. You will be responsible to Blue Shield Life for unpaid Dues prior to the date of cancellation.

Blue Shield Life will honor all timely filed claims for Covered Services provided prior to the effective date of cancellation.

See the Cancellation and Rescission provision for termination for fraud or intentional misrepresentations of material fact.

Termination of Benefits

There is no right to receive Benefits for services provided following termination of the contract. The Contract is issued for a one year period.

Blue Shield Life may terminate you or your Dependent's coverage for cause immediately upon written notice to you for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to or Blue Shield Life; 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 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 Life personnel and providers of services, or, (2) substantially impairs the ability of Blue Shield Life 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 Life within the 31 days following that Dependent's effective date of coverage, Benefits under the Plan will be terminated on the 31st day at 11:59 P.M. Pacific Time.

Notice and Proof of Claim

Notice and Claim Forms

In the event a Dentist does not bill Blue Shield Life directly, you should use a Blue Shield Life Insured Person's Statement of Claim form in order to receive reimbursement. To receive a claim form, written notice of a claim must be given to Blue Shield Life within 20 days of the date of service. If this is not possible, Blue Shield Life must be notified as soon as it is reasonably possible to do so.

When Blue Shield Life receives Notice of Claim, Blue Shield Life will send you an Insured Person's Statement of Claim form for filing proof of a claim. If Blue Shield Life fails to furnish the necessary claim forms within 15 days, you may file a claim without using a claim form by sending Blue Shield Life written proof of claim as described below.

If you receive Covered Services from a Non-Participating Dentist, either you or your Dentist may file a claim using the dental claim form which may be obtained by called Dental Insured Person services at:

888-679-8928

Only claims for Benefits for enhanced dental services for Pregnant Women should be sent to:

Blue Shield Life
Dental Plan Administrator
Coverage for Women during Pregnancy
425 Market Street, 15th Floor
San Francisco, CA 94105

Claims for all other Covered Services rendered by Non-Participating Dentists, should be sent to:

Blue Shield Life
P. O. Box 272590
Chico, CA 95927-2590

Proof of Claim

Blue Shield Life must receive written proof of claim within 90 days after the date of service for which claim is being made from a Participating Dentist and no later than 180 days for claims from a Non-Participating Dentist.
A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured Person was legally unable to notify Blue Shield Life.

Payment of Benefits

Time and Payment of Claims

Claims will be paid promptly upon receipt of written proof and determination that Benefits are payable.

Payment of Claims

Participating Dentists are paid directly by Blue Shield Life.

If the Insured Person receives Covered Services from a Non-Plan Dentist, payment will be made directly to the Subscriber, and the Insured Person is responsible for payment to the Non-Participating Dentist.

Legal Actions
No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of claim is required to be furnished.

Endorsements and Appendices
Attached to and incorporated in this Policy by reference are appendices pertaining to deductibles and premiums. Endorsements may be issued from time to time subject to the notice provisions of the section entitled Duration of the Policy. Nothing contained in any endorsement shall affect this Policy, except as expressly provided in the endorsement.

Notices
Any notice required by this Policy may be delivered by United States mail, postage prepaid. Notices to the Subscriber may be mailed to the address appearing on the records of Blue Shield Life and notice to Blue Shield Life may be mailed to:

Blue Shield Life
50 Beale Street
San Francisco, CA 94105

Commencement or Termination of Coverage
Whenever this Policy provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 a.m. Pacific Time of the commencement date and as of 11:59 P.M. Pacific Time of the termination date.

Identification Cards
Identification cards will be issued by Blue Shield Life to all Insured Persons.

Legal Process
Legal process or service upon Blue Shield Life must be served upon a corporate officer of Blue Shield Life.

Notice
The Subscriber hereby expressly acknowledges its understanding that this Policy constitutes a contract solely between the Subscriber and Blue Shield Life (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Policy.

Dental Customer Services

Questions about Covered Services, Dentists, how to use this 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 telephone number or address which appear below:

888-679-8928

Blue Shield Life
Dental Plan Administrator
425 Market Street, 15th Floor
San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

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

Note: A Dental Plan Administrator 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 Dental Plan Administrator shall make a decision and notify the Subscriber and Dentist within 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

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 888-679-8928. If the telephone inquiry to the Dental Customer Service Department does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Dental Customer Service Representative will initiate on the Subscriber's behalf.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this form from the Dental Customer Service Department. If the Subscriber wishes, the Dental Customer Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to a 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.

888-679-8928

Blue Shield Life
Dental Plan Administrator
425 Market Street, 15th Floor
San Francisco, CA 94105

A Dental Plan Administrator will acknowledge receipt of a written grievance within five (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.

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 Person 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 8:00 a.m. to 6:00 P.M., Monday through 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 www.insurance.ca.gov.

Definitions

Whenever the following definitions are capitalized in this booklet, they will have the meaning stated below.

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

Allowable Amount – the amount a Plan Provider agrees to accept as payment from a Dental Plan Administrator or the billed amount for Non-Plan Dentists.

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

Authorization – the procedure for obtaining the Plan's prior approval for all services provided to Members under the Contract other than your Dental Provider and Emergency Services.

Benefits (Covered Services) – those services which a Member is entitled to receive pursuant to the terms of this Agreement.

Calendar Year – a period beginning at 12:01 A.M. on January 1 and ending at 12:01 A.M. January 1 of the next 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 certain Covered Services after meeting any applicable Deductible.

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

Cosmetic – any procedure, surgery, service, appliance, or supply that is not Dentally Necessary but is solely designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasing or unsightly.

Covered Services (Benefits) – those services which a Member is entitled to receive pursuant to the terms of this Agreement.

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

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

Dental Center – means a Dentist or a dental practice (with one or more Dentists) which has contracted with a Dental Plan Administrator to provide dental care Benefits to Members and to diagnose, provide, refer, supervise and coordinate the provision of all Benefits to Members in accordance with this Agreement.

Dental Necessity (Dentally Necessary) – Benefits are provided only for services that are Dentally Necessary as defined in this section.

1. Services which are of Dental Necessity include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards which, as determined by a Dental Plan Administrator, are:

a. Consistent with the symptoms or diagnosis of the condition; and

b. Not furnished primarily for the convenience of the Member, the attending Dentist or other provider; and

c. Furnished in a setting appropriate for delivery of the Service (e.g., a Dentist's office).

2. If there are two (2) or more Dentally Necessary services that can be provided for the condition, Blue Shield Life will provide Benefits based on the most cost-effective service.

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

Dental Provider (Plan Provider) – means a Dentist or other provider appropriately licensed to provide Dental Care Services who contracts with a Dental Center to provide Benefits to Plan Members in accordance with this Agreement.

Dental Service Plan (Plan) – the Plan issued by Blue Shield Life to the contractholder that establishes the Benefits that Members are entitled to receive from the Plan.

Dentist – a duly licensed Doctor of Dental Surgery or other practitioner who is legally entitled to practice dentistry in the state of California.

Dependent —

1. A Subscriber's legally married spouse or Domestic Partner who is:
   a. A Resident of California (unless a full-time student); and
   b. Not covered for Benefits as a Subscriber; and
   c. Not legally separated from the Subscriber; or
2. A Subscriber's Domestic Partner who is:
   a. Not covered for Benefits as a Subscriber; and
   b. A Resident of California.
3. A child of, adopted by, or in legal guardianship of the Subscriber, spouse or Domestic Partner, who is unmarried and is not in a domestic partnership. 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 and who is less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by the Plan 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 child will be continued upon the following conditions:
   a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
   b. the Subscriber, spouse, or Domestic Partner must submit to Blue Shield 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 must be submitted to Blue Shield Life on the following schedule:
      i. within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and
      ii. annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

Domestic Partner – an individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex Domestic Partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

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

Elective Dental Procedure – any dental procedures which are unnecessary to the dental health of the patient, as determined by a Dental Plan Administrator.

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

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

Endodontics – Dental Care Services specifically related to necessary procedures for treatment of disease of the pulp chamber and pulp canals, not requiring hospitalization.

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.

Insured Person – or Dependent who has completed an enrollment form approved by Blue Shield Life and for whom coverages provided by this Policy are in effect.

Non-Plan Dentist – a Dental Center, Plan Specialist, or other Dental Provider who has not signed a service contract with a Dental Plan Administrator to provide dental services to Insured Persons.

Open Enrollment Period – that period of time set forth in the Contract during which eligible individuals and their Dependents may enroll in the Plan.

Oral Surgery - Dental Care Services specifically related to the diagnosis and the surgical and adjunctive treatment of diseases, injuries and defects of the mouth, jaws and associated structures.

Orthodontics (Orthodontic) – Dental Care Services specifically related to necessary services to Insured Persons.

Palliative Treatment – therapy designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.

Pedodontics – Dental Care Services related to the diagnosis and treatment of conditions of the teeth and mouth in children.

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

Plan – the Specialty Duo Dental Plan or Blue Shield of California Life & Health Insurance Company.

Plan Dentist – a Dental Center, Plan Specialist, or other Dental Provider who has an agreement with a Dental Plan Administrator to provide Plan Benefits to Members.

Plan Specialist – a Dentist who is licensed or authorized by the State of California to provide specialized Dental Care Services as recognized by the appropriate specialty board of the American Dental Association, and, who has an agreement with a Dental Plan Administrator to provide Covered Services to Members on referral by Dental Provider.

Prosthesis – an artificial part, appliance or device used to replace a missing part of the body.

Prosthodontics – Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth.

Resident of California – an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

Service Area – that geographic area served by the Plan.

Subscriber – an individual who satisfies the eligibility requirements of this Policy, and who is enrolled and accepted by the Plan as an Insured Person, and has maintained Plan membership in accord with this Policy.

Surcharge – an additional fee which is charged to a member for a Dental Care Service which is not provided for in the Dental services Contract or disclosed in the Evidence of Coverage.

Treatment in Progress – partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken. Ongoing Orthodontic cases are not considered Treatment in Progress under this definition.

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 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357.
English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請撥打1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신1-866-346-7198 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は, 1-866-346-7198 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره 1-866-346-7198تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

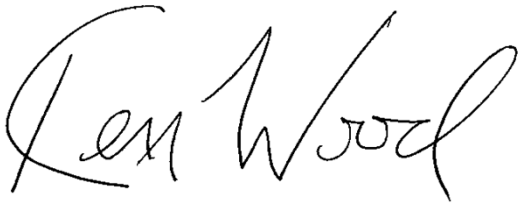
សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم 1-866-346-7198. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

IN WITNESS WHEREOF, Blue Shield of California Life & Health Insurance Company, through its duly authorized Officers, execute this Policy, to take effect on the Insured Person's effective date.

Seth A. Jacobs, Secretary
Blue Shield of California Life & Health Insurance Company



Ken Wood
President & Chief Executive Officer
Blue Shield of California Life & Health Insurance Company

Dental Customer Service Telephone Numbers:

Blue Shield Life
Dental Plan Administrator
1-888-679-8928

Blue Shield Life
1- 888-271-4880

Dental Customer Service Correspondence Addresses:

Blue Shield Life
Dental Plan Administrator
Dental Customer Service
425 Market Street, 15th Floor
San Francisco, CA 94105

Claims for Benefits for Enhanced Dental Services for Pregnant Women should be sent to:
Blue Shield Life / CAT Team
Dental Plan Administrator
Coverage for Women during Pregnancy
425 Market Street, 15th Floor
San Francisco, CA 94105

Claims for all other Covered Services should be sent to:
Blue Shield Life
P. O. Box 272590
Chico, CA 95927-2590

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Specialty Duo℠ Vision Plan

Blue Shield of California Life & Health Insurance Company

Policy

Individual and Family Plan

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blueshieldca.com

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Specialty Duo℠ Vision Plan

Policy for Individuals and Families

This vision Policy is issued by Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"), to the Insured Person who submitted a complete and appropriate application. In consideration of statements made in the application and timely payment of premiums, Blue Shield Life agrees to provide the Benefits of this Policy. The Benefits provided by this vision Policy do not qualify as an essential health benefit as defined in Section 1302(b) of the Affordable Care Act.

NOTICE TO NEW INSURED PERSONS

Please read this Policy carefully. If you have questions, contact Blue Shield Life. You may surrender this Policy by delivering or mailing it within ten (10) days from the date it is received by you, to BLUE SHIELD LIFE, 50 BEALE STREET, SAN FRANCISCO, CA 94105. Immediately upon such delivery or mailing, the Policy shall be deemed void from the beginning, and premiums paid will be refunded.

IMPORTANT!

No Insured Person has the right to receive the Benefits of this Plan for services or supplies furnished following termination of coverage. Benefits of this 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 Policy. Benefits may be modified during the term of this Plan as specifically provided under the terms of this Policy 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 the modification. There is no vested right to receive the Benefits of this Plan.

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Blue Shield of California Life & Health Insurance Company

Summary of Benefits

This Summary of Benefits describes vision Plan Benefits and sets forth any Copayment that is the responsibility of the Insured Person for services received. Please refer to the "Benefits," "Covered Services" and "General Exclusions and Limitations" sections for a description of the Benefits, condition, limitations and exclusions of this Policy.

Procedure	Allowable Amount	
	Participating Providers	**Non-Participating Providers**
	Services are covered in full except as noted otherwise with a maximum Allowable Amount.	Services are covered up to the following Allowable Amounts. Insured Persons are responsible for all charges in excess of these amounts.
Comprehensive examination [1]		
Ophthalmologic	100%	$60
Optometric	100%	$50
Lenses – Note: Lenses are covered less a $25 Copayment for Materials. This Copayment is applicable per prescription and per Insured Person.		
Single Vision	100%	$43
Bifocal	100%	$60
Trifocal	100%	$75
7.25 Diopter, or more	100%	$12
Aphakic Monofocal	100%	$120
Aphakic Multiofocal	100%	$200
Lenticular Monofocal	100%	$120
Lenticular Multifocal	100%	$200
Prism 1 ½ to 4 Diopters	100%	$10
Prism 4 ½ to 10 Diopters	100%	$16
Slab-off prism (per lens)	100%	$35
Lens Options		
Polycarbonate Lenses (only for Dependent children)	$100	$75
Contact Lenses – Note: Contact lenses are covered less a $25 Copayment for Materials. This Copayment is applicable per prescription and per Insured Person.		

Non-Elective (Medically Necessary) Contact Lenses (one pair) – Hard Lenses [1, 3]	100%	$200
Non-Elective (Medically Necessary) Contact Lenses (one-year supply) – Soft Lenses [1, 3]	100%	$250
Procedure	**Allowable Amount**	
	Participating Providers	**Non-Participating Providers**
	Services are covered in full except as noted otherwise with a maximum Allowable Amount.	Services are covered up to the following Allowable Amounts. Insured Persons are responsible for all charges in excess of these amounts.
Elective (Cosmetic or Convenience) Contact Lenses – Hard (one pair) or Soft Lenses (one-year supply) [1, 3]	$120 [4]	$120 [4]
Frames		
Frames	$100 [5]	$40
Plano Sunglasses		
Plano (non-prescription) Sunglasses [6]	$100 [5]	Not covered
Diabetes Management Referral		
Diabetes Management Referral [7]	100%	Not covered

FOOTNOTES

[1] The comprehensive examination Benefit does not include fitting fees for contact lenses; however the contact lens allowance may be used towards fitting fees.

[2] Each pair of standard lenses includes Pink or Rose tint #1 or #2 in the allowance and up to 61mm in size.

[3] See the Definitions section for the definition of Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.

[4] Allowance toward the cost of contact lenses is in lieu of other eyewear Benefits — the difference between the Allowance and the provider's charge is the responsibility of the Insured Person, whether dispensed by a Participating Provider or by a Non-Participating Provider. The online provider is a network provider and you may choose to use your Benefits online. Note, if you choose to take the eyeglasses you purchased online to your preferred eye care provider for fittings or adjustments, you may incur a fitting or adjustment fee which is not covered under your vision insurance Plan.

[5] When the Participating Provider uses wholesale or warehouse pricing, the maximum allowable frame allowance will be as follows: wholesale allowance: $66.04, warehouse allowance: $69.09. Note that this pricing replaces the frame allowance shown in the Summary of Benefits. If a more expensive frame is selected at a provider location that uses wholesale or warehouse pricing, the Insured Person is responsible for the additional cost above the wholesale or warehouse allowance. Participating Providers using wholesale or warehouse pricing are identified in the Directory of Participating Providers.

Note: The difference between the Allowable Amount under the Summary of Benefits and the charges for more expensive frame styles or unusual lenses, such as oversize, no-line bifocal, or a material other than ordinary plastic, will be the Insured Person's responsibility, whether dispensed by a Participating Provider or Non-Participating Provider. Participating Providers allow a selection of frame styles that retail up to $75.00 - $150.00 with lenses that fit an eye size less than 61 millimeters. If a more expensive frame is selected, the Insured Person is responsible for the additional retail cost above the $100.00. If the lenses are 61 millimeters or over, any difference between the allowance and the provider's charge is the Insured Person's responsibility. Contact lenses, in lieu of frames and lenses, are covered up to an amount of $120.

[6] The plano (non-prescription) sunglasses Benefit is for an Insured Person who has had PRK, LASIK, or custom LASIK vision correction laser surgery. An eye exam by a Participating Provider or a note from the surgeon who performed the laser surgery is required to verify laser surgery. The surgeon's note must be submitted with the claim for plano sunglasses. The plano sunglasses Benefit is offered in lieu of the frame Benefit, not in addition to the frame Benefit. This Benefit may only be obtained from Participating Providers and only once in a consecutive 24-month period.

[7] Low vision is a bilateral impairment to vision that is so significant that it cannot be corrected with ordinary eyeglasses, contact lenses, or intraocular lens implants. Although reduced central or reading vision is common, low vision may also result from decreased peripheral vision, a reduction or loss of color vision, or the eye's inability to properly adjust to light, contrast, or glare. It can be measured in terms of visual acuity of 20/70 to 20/200. Equipment are special magnifiers that make print easier to read. A report from the provider and prior authorization from the VPA is required.

[8] A diabetes management referral is a referral to a Blue Shield disease management program and is only available to Insured Persons with coverage under a Blue Shield of California or Blue Shield Life medical plan. Blue Shield's disease management program is informed when, during the course of a normal eye exam, the patient is known to have, or felt to be at risk for diabetes.

Introduction to the Specialty Duo Vision Plan

The Specialty Duo (Dental + Vision) package consists of a dental plan and a vision plan, which is offered at a package rate. This Policy describes the benefits of the Specialty Duo Vision Plan, the vision plan in the Specialty Duo (Dental + Vision) package.

Blue Shield Life's vision plans are administered by the Vision Plan Administrator (VPA). The VPA is a vision care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of eyewear and eye exams covered under this Vision Plan through a network of Participating Providers. The VPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Providers.

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

Waiting Period

There is a ninety (90) day Waiting Period before any Benefits are available under this Plan. This Waiting Period begins on the Insured Person's Effective Date of coverage.

Before Obtaining Vision Services:

You are responsible for assuring that the vision provider you choose is a Participating Provider. Note: A Participating Provider's status may change. It is your obligation to verify whether the vision provider you choose is currently a Participating Provider in case there have been any changes to the list of Participating Providers. A list of Participating Providers located in your area can be obtained by contacting the VPA at 1-877-601-9083. You may also access a list of Participating Providers through Blue Shield's Internet site located at http://www.blueshieldca.com.

Continuity of Care by a Terminated Provider

Insured Persons who are being treated for acute conditions, serious chronic conditions, or who are children from birth to 36 months of age, or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving a Vision Plan Administrator's network of Participating Providers. 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 an Insured Person is entitled to receive Covered Services from a terminated provider under the preceding Continuity of Care provision, and the provider has agreed to the VPA's contractual terms and compensation rate, the responsibility of the Insured Person to that provider for Covered Services rendered under the Continuity of Care provision shall be no greater than for the same Covered Services rendered by a Participating Provider in the same geographic area.

Premiums

Monthly premiums are as stated in the Appendix. Blue Shield Life offers a variety of options and methods by which you may pay your premiums. Please call Customer Service at the telephone number indicated on the last page of this booklet to discuss these options or visit the Blue Shield Life internet site at http://www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield Life
P.O. Box 51827
Los Angeles, CA 90051-6127

Additional premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield Life a tax or license fee, which is calculated upon, base premiums or Blue Shield Life's gross receipts or any portion of either. premiums may increase from time to time as determined by Blue Shield Life. You will receive sixty (60) days written notice of any changes in the monthly premiums for this Plan.

Conditions of Coverage

Eligibility and Enrollment

1. To enroll and continue enrollment, an Insured Person must meet all of the eligibility requirements of the Plan.
2. Enrollment of Insured Persons or Dependents is not effective until Blue Shield Life approves an application and accepts the applicable premiums. Only Blue Shield Life can approve applications.
3. An applicant, upon approval by Blue Shield Life of the application, is entitled to the Benefits of this Policy after completion of the ninety (90) day Waiting Period.

   By completing an application, the Insured Person and/or Dependent(s) agrees to cooperate with Blue Shield Life by providing, or providing access to, documents and other information that the Plan may request to corroborate the information for coverage. If the Insured Person and/or Dependent(s) fail or refuse to provide these documents or information to Blue Shield Life, coverage under this Plan may be cancelled.
4. The Effective Date of the Benefits of a newborn child will be the date of birth if the Insured Person contacts Blue Shield Life at the Customer Service telephone number listed at the back of this booklet to have the newborn child added to this Policy as a Dependent. Such request must be made within 31 days of the newborn child's date of birth. If a request to add the child as a Dependent is not made within 31 days of birth, the coverage for that child shall terminate on the 31st day at 11:59 P.M. Pacific Time.

   If the Insured Person wishes to add a newborn child as a Dependent 32 or more days after birth, coverage will not be retroactive and there will be a gap in coverage. See Paragraph 6. below.
5. The Effective Date of Benefits for an adopted child will be the date the Insured Person or spouse or Domestic Partner has the right to control the child's health care, if the Insured Person requests the child be added to this Pol-

icy as a Dependent. Such request must be made within 31 days of the date the Insured Person, spouse, or Domestic Partner has the right to control the child's health care. If a request to add the child as a Dependent is not made within 31 days of the date the Insured Person, spouse, or Domestic Partner has the right to control the child's health care, the coverage for that child shall terminate on the 31st day at 11:59 P.M. Pacific Time.

To add a child placed for adoption to this Policy as a Dependent, the Insured Person must contact Blue Shield Life at the Customer Service telephone number listed at the back of this booklet. The Customer Service Department will advise the Insured Person of the exact process for adding a child placed for adoption as a Dependent, including, but not limited to, the necessary documentation and how the documentation shall be submitted to Blue Shield Life. Enrollment requests for an adopted child must be accompanied by evidence of the Insured Person's or spouse's or Domestic Partner's right to control the child's health care, which includes a facility minor release report, a medical authorization form, or a relinquishment form.

If the Insured Person wishes to add a child placed for adoption as a Dependent 32 or more days after the date the Insured Person, spouse, or Domestic Partner has the right to control the child's health care, coverage will not be retroactive and there will be a gap in coverage.

6. If a court has ordered that you provide coverage for your spouse or Domestic Partner, under your Plan, their coverage will become effective within 31 days of presentation of a court order.

7. The Insured Person can also add a Dependent under the age of 26 for a qualifying event as described below, as long as they apply during a period no longer than 63 days after any event listed below:

   a. Losing Dependent coverage due to:
      i. The termination or change in employment status of this Dependent or the person through whom this Dependent was covered; or
      ii. The cessation of an employer's contribution toward an employee or Dependent's coverage; or
      iii. The death of the person through whom this Dependent was covered as a Dependent; or
      iv. Legal separation or divorce; or

   b. Loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program, or the Medi-Cal Program; or

   c. Adoption of the child; or

   d. The child becomes a Resident of California during the month that was not the child's birth month; or

   e. The child is born as a Resident of California and did not enroll in the month of birth; or

   f. The child is mandated to be covered pursuant to a valid state or federal court order (presentation of a court order by the district attorney, or upon presentation of a court order by request by a custodial party, of Section 3751.5 of the California Family Code).

Please consider your options carefully by failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now.

Limitation on Enrollment

1. Insured Persons must be Residents of California. Upon change of residence to another jurisdiction, this Policy will terminate.

2. Dependent Benefits shall be discontinued as of the following, except as specifically set forth in the definition of Dependent in the section entitled Definitions:

   a. The date the Dependent child attains age 26;

   b. The date the Dependent spouse or Domestic Partner enters a final decree of divorce, annulment, or dissolution, or termination of domestic partnership or marriage from the Insured Person.

3. If the Insured Person seeks to add a Dependent under age 26 to the Policy other than a Dependent described in the paragraphs 3, 4, 5, 6 or 7 of the section entitled Enrollment, this will result in Blue Shield Life recalculation or reassigning the appropriate premiums based on underwriting review of the Dependent.

4. If an Insured Person commits any of the following acts, he will immediately lose eligibility to continue enrollment:

   a. Abusive or disruptive behavior which: (1) threatens the life or well-being of Blue Shield Life personnel or providers of services; or (2) substantially impairs the ability of Blue Shield Life to arrange for services to the Insured Person; or (3) substantially impairs the ability of providers of service to furnish services to the Insured Person or to other patients.

   b. Failure or refusal to provide Blue Shield Life access to documents and other information necessary to determine eligibility or to administer Benefits under the Plan.

Duration of the Policy

This Policy shall be renewed upon receipt of prepaid Premiums. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in Premiums or benefits, including but not limited to Covered Services, Deductible, Copayment, coinsurance, and Calendar Year Maximum Payment, are effective after 60 days notice to the Insured Person's address of record with Blue Shield Life.

Renewal of the Policy

Blue Shield Life shall renew this Policy, except under the following conditions:

1. Non-payment of premiums;

2. Fraud, misrepresentation, or omission of material fact;
3. Termination of plan type by Blue Shield Life;
4. Insured Person moves out of California or the Insured Person is no longer a Resident of California;
5. If a bona fide association arranged for the Insured Person's coverage under this Policy, when that Insured Person's membership in the association ceases.

Termination / Reinstatement of the Policy

This Policy may be terminated or cancelled as follows:

1. Termination by the Insured Person:

   An Insured Person desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.

2. Termination by Blue Shield Life through cancellation:

   Blue Shield Life may cancel this Policy with five (5) days written notice for the following reasons:

   a. Fraud or deception in obtaining, or attempting to obtain, Benefits under this Policy; or

   b. Knowingly permitting fraud or deception by another person in connection with this Policy, such as, without limitation, permitting someone to seek Benefits under this Policy, or improperly seeking payment from Blue Shield Life for Benefits provided.

   Cancellation of the Policy under this section will terminate the Policy five (5) days after the date that written notice of termination is mailed to the Insured Person. It is not retroactive to the original Effective Date of the Policy.

3. Termination by Blue Shield Life if Insured Person moves out of California:

   Blue Shield Life may cancel this Policy upon thirty (30) days written notice if the Insured Person moves out of California. See the section entitled Transfer of Coverage for additional information.

   Within 30 days of the notice of cancellation under sections 2 or 3 above, Blue Shield Life shall refund the prepaid premiums, if any, that Blue Shield Life determines will not have been earned as of the termination date. Blue Shield Life reserves the right to subtract from any such premiums refund any amounts paid by Blue Shield Life for Benefits paid or payable by Blue Shield Life prior to the termination date.

4. Termination by Blue Shield Life due to withdrawal of the Policy from the market:

   Blue Shield Life may terminate this Policy together with all like Policies to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll in any other individual vision Policy without regard to health status-related factors.

5. Cancellation of the Policy for non-payment of premiums:

   Blue Shield Life may cancel this Policy for failure to pay the required premiums, when due. If the Policy is being cancelled because you failed to pay the required premiums when due, then coverage will end 30 days after the date for which these premiums are due. You will be liable for all premiums accrued while this Policy continues in force including those accrued during this 30 day grace period.

   Within five (5) business days of canceling Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

   a. That the Policy has been cancelled, and the reasons for cancellation; and

   b. The specific date and time when coverage for you ended.

6. Reinstatement of the Policy after termination for non-payment:

   If the Policy is cancelled for non-payment of premiums the Plan will permit reinstatement of the Policy or coverage twice during any twelve-month period, without a change in premiums and without consideration of your medical condition, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

   If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Plan may impose different premiums and consider your medical condition.

Claims Review

The Plan reserves the right to review all claims to determine if any exclusions or limitations apply.

Blue Shield Life may use the services of vision care consultants, peer review committees of professional societies, and other consultants to evaluate claims.

Benefits

Blue Shield Life will pay for Covered Services rendered by Participating Providers in full less the applicable Copayment shown in the Summary of Benefits.

For Covered Services rendered by Non-Participating Providers, Blue Shield Life will pay up to the amounts listed in the Summary of Benefits. The Insured Person will be responsible for all charges in excess of those amounts plus the applicable Copayment.

Covered Services and Supplies

Covered Services under this Specialty Duo Vision Plan are limited to the following:

1. One comprehensive eye examination in a consecutive 12 month period. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services

constitute a single service but need not be performed at one session. The service may include history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry and usually determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

You are responsible for a Copayment for the annual comprehensive eye examination [and for the purchase of frames, lenses or contact lenses] as stated in the Summary of Benefits.

2. One frame in a consecutive 24-month period.
3. One of the following in a consecutive [12-24] month period [or at a 12 month interval if the examination indicates a Prescription Change]
   a. One pair of lenses, or
   b. One Pair of Non-Elective (Medically Necessary) hard Contact Lenses or a one-year supply of Non-Elective (Medically Necessary) soft Contact Lenses, which are lenses following cataract surgery; or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia; or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters). A report from the provider and prior authorization from the VPA is required, or
   c. Elective Contact Lenses up to the Benefit allowance (for cosmetic reasons or for convenience) when provided in lieu of other eyewear. The contact lens allowance may be used towards a contact lens fitting fee. You are responsible for requesting this information from your provider.
4. Polycarbonate lenses for Dependent children covered by a Participating Provider up to $100 or by a Non-Participating Provider up to $75 in a consecutive 24 consecutive month period or at a 12-month interval if the examination indicates a Prescription Change.
5. Low vision is a bilateral impairment to vision that is so significant that it cannot be corrected with ordinary eyeglasses, contact lenses, or intraocular lens implants. Although reduced central or reading vision is common, low vision may also result from decreased peripheral vision, a reduction or loss of color vision, or the eye's inability to properly adjust to light, contrast, or glare. It can be measured in terms of visual acuity of 20/70 to 20/200. The need for supplemental low vision testing is triggered during a comprehensive eye exam. The supplemental low vision testing may only be obtained from Participating Providers and only once in a consecutive 12 month period. A report from the provider and prior authorization from the VPA is required.
6. The plano (non-prescription) sunglasses Benefit is only for Insured Persons who have had PRK, LASIK, or custom LASIK vision correction surgery. An eye exam by a Participating Provider or a note from the surgeon who performed the laser surgery is required to verify laser surgery. The surgeon's note must be submitted with the claim for plano sunglasses. The plano sunglasses Benefit is offered in lieu of the frame Benefit, not in addition to the frame Benefit. This Benefit may only be obtained from Participating Providers and only once in a consecutive 24-month period.
7. One diabetes management referral per calendar year to a Blue Shield disease management program for Insured Persons enrolled in a Blue Shield of California or Blue Shield Life medical plan. The VPA will notify Blue Shield disease management program, subsequent to the annual comprehensive eye exam, when you are known to have or be at risk for diabetes.

General Exclusions and Limitations

Exclusions

Unless exceptions to the following are specifically made elsewhere in this booklet, no Benefits are provided for:

1. Orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no Prescription Change is indicated;
2. Replacement or repair of lost or broken lenses, contact lenses, or frames except as provided under this Policy;
3. Any eye examination required by an employer as a condition of employment;
4. Medical or surgical treatment of the eyes;
5. Contact lenses, except as specifically provided under this policy;
6. Artistically painted lenses;
7. Plano (non-prescription) lenses;
8. Services for or incident to any injury arising out of, or in the course of any employment for salary, wage or profit if such injury or disease is covered by workers' compensation law, occupational disease law or similar legislation. However, if 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 Blue Shield Life for the treatment of the injury or disease;
9. Services required by any government agency or program, Federal, state, or subdivision thereof;
10. Services and Materials for which the Insured Person is not legally obligated to pay, or services or Materials for which no charge is made to the Insured Person;
11. Services not specifically listed as a Benefit; and
12. Comprehensive examination Benefit does not include fitting fees for contact lenses.

Payment of Benefits

Prior to service, the Insured Person should consult their Benefit information for coverage details. The Insured Person may locate a Participating Provider by calling the VPA's Customer Service Department at 1-877-601-9083 or online at www.blueshieldca.com. The Insured Person should make an appointment with a Participating Provider identifying themselves as a Blue Shield Life/VPA Insured Person. The Participating Provider will submit a claim for Covered Services on line or by claim form obtained from the VPA.

Participating Providers will accept Blue Shield Life's payment as payment in full except as noted in the Schedule of Benefits. When services are provided by a Non-Participating Provider, the Insured Person must submit a Vision Service Report (claim form C-4669-61) which may be obtained from our website at www.blueshieldca.com. This form must be completed in full and submitted with all related receipts to:

Blue Shield Life
Vision Plan Administrator
P O Box 25208
Santa Ana, CA 92799-5208

Information regarding Insured Person Non-Participating Provider Benefits may be found by consulting the Insured Person's Benefit information or by calling Blue Shield Life / VPA Customer Service at 1-877-601-9083.

The Insured Person will be responsible for any difference between the amount billed by a Non-Participating Provider and the amount paid by Blue Shield Life. The VPA will may payment directly to a Participating Provider or to the Insured Person for the services of a Non-Participating Provider. A listing of Participating Providers may be obtained from the VPA by calling the telephone number listed in this Policy.

Every Participating Provider's contract stipulates the Insured Person shall not be responsible to the Participating Provider for compensation with respect to any services to the extent they are provided in this vision Benefit. When services are provided by a Non-Participating Provider, the Insured Person is responsible for any amount Blue Shield Life does not pay. However, if an Insured Person is receiving services from a Participating Provider as of the date that such provider's contract is terminated, the Insured Person's responsibility to that provider for services rendered subsequent to that termination date shall be no greater than it was for services rendered immediately prior to that termination date, until the first to occur of the following:

1. The date that the services being rendered by such providers are completed;
2. The date that Blue Shield Life makes reasonable and appropriate provision for the assumption of such services by another Participating Provider; or
3. The date that coverage for such Insured Person is terminated.

Participating Providers submit claim for payment after their services have been received. If you receive services from a Non-Participating Provider, you or your provider may also submit claims for payment after services have been received.

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

Choice of Providers

An Insured Person may select any licensed ophthalmologist, optometrist, or optician to provide Covered Services hereunder, including such providers outside of California. A Directory of Participating Providers is available on Blue Shield Life's internet site located at http://www.blueshieldca.com. You may also obtain this information from the VPA by calling the telephone number listed in this vision Benefit.

Reductions - Third Party Liability

If an Insured Person is injured or becomes ill due to the act or omission of another person (a "third party"), the Plan shall, with respect to services required as a result of that injury, provide the Benefits of this Policy and have an equitable right to restitution, reimbursement, or other available remedy to recover the amounts Blue Shield paid for services provided to the Insured Person on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Insured Person, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

Blue Shield's right to restitution, reimbursement, or other available remedy is against any recovery the Insured Person receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Insured Person has been "made whole" by the Recovery. Blue Shield's right to restitution, reimbursement, or other available remedy will be calculated in accordance with California Civil Code Section 3040.

The Insured Person is required to:

1. Notify the Plan in writing of any actual or potential claim or legal action which such Insured Person expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with the Plan to execute any forms or documents needed to enable Blue Shield Life to enforce its right to restitution, reimbursement, or other available remedies; and,
3. Agree in writing to reimburse Blue Shield Life for Benefits paid by Blue Shield Life from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide the Plan with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the

third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield Life, in writing, within ten (10) days after any Recovery has been obtained.

An Insured Person's failure to comply with items 1. through 5., shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan.

Further, if the Insured Person receives services from a participating hospital for such injuries or illness, the hospital has the right to collect from the Insured Person the difference between the amount paid by Blue Shield Life and the hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Insured Person for medical expenses. The hospital's right to collect shall be in accordance with California Civil Code Section 3040.1

General 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 back of this booklet or 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 Number:
1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@blueshieldca.com

Access to Information
Blue Shield Life may need information from medical providers, from other carriers or other entities, or from you, in order to administer Benefits and eligibility provisions of this Policy. You agree that any provider or entity can disclose to Blue Shield Life that information that is reasonably needed by Blue Shield Life. You agree to assist Blue Shield Life in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield Life with information in your possession. Failure to assist Blue Shield Life 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 Life will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Independent Contractors
Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions of any person providing services.

Entire Policy: Changes
This Policy, including the appendices, constitutes the entire agreement between parties. Any statement made by an Insured Person shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Policy shall be valid unless approved by a corporate officer of Blue Shield Life and a written endorsement issued. No agent has authority to change this Policy or to waive any of its provisions.

Benefits, such as Covered Services, Calendar Year Benefits, Deductible, Copayment, Coinsurance, maximum per Insured Person Calendar Year Copayment/Coinsurance responsibility, or maximum per Insured Person Calendar Year Copayment/Coinsurance responsibility amounts are subject to change at any time. Blue Shield Life will provide at least 60 days written notice of any such change.

Benefits provided after the Effective Date of any change will be subject to the change. There is no vested right to obtain Benefits.

Time Limit on Certain Defenses
After an Insured Person has been covered under this Policy for two (2) consecutive years, Blue Shield Life will not use any omission, misrepresentation, or inaccuracy made by the applicant in an individual application to limit, cancel or rescind a Policy, deny a claim, or raise premiums.

Grace Period
After payment of the first premium, the Insured Person is entitled to a grace period of 30 days for the payment of any premium due. During this grace period, the Policy will remain in force. However, the Insured Person will be liable for payment of premiums accruing during the period the Policy continues in force.

Notice and Proof of Claim

Notice and Claim Forms
In the event a Participating Provider does not bill Blue Shield Life directly, you should use a Blue Shield Life Insured Person's Statement of Claim form in order to receive reimbursement. To receive a claim form, written notice of a claim must be given to Blue Shield Life within 20 days of the date of ser-

vice. If this is not possible, Blue Shield Life must be notified as soon as it is reasonably possible to do so.

When Blue Shield Life receives a Notice of Claim, Blue Shield Life will send you an Insured Person's Statement of Claim form for filing proof of a claim. If Blue Shield Life fails to furnish the necessary claim forms within 15 days, you may file a claim without using a claim form by sending Blue Shield Life written proof of claim as described below.

If you receive Covered Services from a Non-Participating Provider, either you or the provider may file a claim using the claim form which may be obtained by calling 1-877-601-9083 or visiting the Blue Shield website at www.blueshieldca.com.

Proof of Claim
Blue Shield Life must receive written proof of claim within 90 days after the date of service for which claim is being made from a Participating Provider and no later than 180 days for claims from a Non-Participating Provider.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured Person was legally unable to notify Blue Shield Life.

Payment of Benefits

Time and Payment of Claims
Claims will be paid promptly upon receipt of written proof and determination that Benefits are payable.

Payment of Claims
Participating Providers will submit a claim for Covered Services on line or by claim form obtained from the VPA and are paid directly by Blue Shield Life.

If the Insured Person receives services from a Non-Participating Provider, payment will be made directly to the Insured Person, and the Insured Person is responsible for payment to the Non-Participating Provider.

Legal Actions
No action at law in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of claim is required to be furnished.

Endorsements and Appendices
Attached to and incorporated in this Policy by reference are appendices pertaining to deductibles and premiums. Endorsements may be issued from time to time subject to the notice provisions of the section entitled Duration of the Policy. Nothing contained in any endorsement shall affect this Policy, except as expressly provided in the endorsement.

Notices
Any notice required by this Policy may be delivered by United States mail, postage prepaid. Notices to the Insured Person may be mailed to the address appearing on the records of Blue Shield Life and notice to Blue Shield Life may be mailed to:

Blue Shield Life
50 Beale Street
San Francisco, CA 94105

Commencement or Termination of Coverage
Whenever this Policy provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 a.m. Pacific Time of the commencement date and as of 11:59 P.M. Pacific Time of the termination date.

Legal Process
Legal process or service upon Blue Shield Life must be served upon a corporate officer of Blue Shield Life.

Notice
The Insured Person hereby expressly acknowledges its understanding that this Policy constitutes a contract solely between the Insured Person and Blue Shield Life (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Insured Person further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Insured Person for any of the Plan's obligations to the Insured Person created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Policy.

Customer Service

If you have a question about services, providers, Benefits, how to use this Policy, or concerns regarding the quality of care or access to care that you have experienced, you may contact Blue Shield Life's Customer Service Department at:

1-714-619-4660 or
1-877-601-9083

Blue Shield of California Life & Health Insurance Company
P. O. Box 25208
Santa Ana, CA 92799-5208

www.blueshieldca.com

The hearing impaired may contact the Customer Service Department through the toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

Grievance Process

Insured Persons, a designated representative, or a provider on behalf of the Insured Person, may contact the Vision Cus-

tomer Service Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Insured Persons may contact the Vision Customer Service at the telephone number noted above. If the telephone inquiry to Vision Customer Service does not resolve the question or issue to the Insured Person's satisfaction, the Insured Person may request a grievance at that time, which the Vision Customer Service Representative will initiate on the Insured Person's behalf.

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

1-877-601-9083
Vision Plan Administrator
P. O. Box 25208
Santa Ana, CA 92799-5208

A Vision Plan Administrator will acknowledge receipt of a written grievance within five (5) calendar days. Grievances are resolved within 30 days.

The grievance system allows Insured Persons to file grievances for at least 180 days following any incident or action that is the subject of the Insured Person's dissatisfaction.

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 Person 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 8:00 a.m. to 5:00 P.M., Monday through 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 www.insurance.ca.gov.

Definitions

Whenever the following definitions are capitalized in this booklet, they will have the meaning stated below.

Allowable Amount – the contracted VPA allowance for the service (or services) rendered, as shown in the "Summary of Benefits", is such amount as the Participating Provider and the contracted VPA have agreed will be accepted as payment for the service(s) rendered.

Blue Shield Life – Blue Shield of California Life & Health Insurance Company, a California corporation licensed as a life and disability insurer.

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

Coinsurance – the percentage of the Allowable Amount that an Insured Person is required to pay for specific services after meeting any applicable Deductible.

Copayment – the amount that an Insured Person is required to pay for certain Covered Services.

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

Dependent –

1. A Insured Person's legally married spouse who is:
   a. Resident of California; and
   b. Not covered for Benefits as an Insured Person; and
   c. Not legally separated from the Insured Person; or

2. A Insured Person's Domestic Partner, who is:
   a. Not covered for Benefits as an Insured Person; and
   b. A Resident of California.

3. A Insured Person's, spouse's, or Domestic Partner's child (including any stepchild or child placed for adoption or any other child for whom the Insured Person, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction) not covered for Benefits as an Insured Person who is:
   a. Resident of California (unless a full-time student); and
   b. Less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship); or

And who has been enrolled and accepted by Blue Shield Life as a Dependent and has maintained membership in accordance with this Policy.

Note: Children of Dependent children (i. e. grandchildren of the Insured Person, spouse, or Domestic Partner) are not Dependents unless the Insured Person, 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 Insured Person, spouse, or Domestic Partner for sup-

port and maintenance and be incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition;

b. The Insured Person, spouse, or Domestic Partner submits to the Plan a physician's written certification of disability within 60 days from the date of the Plan's request; and

c. Thereafter, certification from a physician is submitted to the Plan on the following schedule:
   i. Within 24 months after the month when the Dependent would otherwise have been terminated; and
   ii. Annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

Domestic Partner – an individual who is personally related to the Insured Person by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Effective Date – the date an applicant meets all enrollment and prepayment requirements and is accepted by Blue Shield Life.

Insured Person – an Insured Person or Dependent who has completed an enrollment form approved by Blue Shield Life and for whom coverages provided by this Policy are in effect.

Materials – any type of lenses, including contact lenses (Medically Necessary or Elective), frames, and low vision aids.

Non-Elective (Medically Necessary) Contact Lenses – lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters).

Non-Participating Provider – a licensed ophthalmologist, optometrist, or dispensing optician who has not certified and not accepted the terms of the Policy.

Participating Provider – a provider who has agreed to accept Blue Shield Life's payment, plus any applicable Insured Person Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to the Insured Person.

Plan – the vision plan indicated on the cover of this document.

Prescription Change – any of the following:

1. A change in prescription of 0.50 diopter or more; or
2. A Shift in axis of astigmatism of 15 degrees; or
3. A difference in vertical prism greater than 1 prism diopter; or
4. A change in lens type (for example contact lenses to glasses or single vision lenses to bifocal lenses).

Resident of California – an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

Vision Plan Administrator (VPA) – a vision care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield Life to administer delivery of eyewear and eye exams covered under this vision Plan through a network of Participating Providers. The VPA also contracts with Blue Shield Life to serve as a claims administrator for the processing of claims for services received from Non-Participating Providers.

Vision Plan Information Card – a card mailed to the Insured Person that is not required to access care and is not a verification of eligibility in the Specialty Duo (Dental + Vision). The Vision Plan Information Card contains telephone numbers, a website address, and other information to assist the Insured Person and providers in obtaining benefit information as well as verify eligibility in the Specialty Duo (Dental + Vision).

Waiting Period – no Benefits are paid or otherwise available during the first ninety (90) consecutive days of coverage. Each Insured Person must satisfy this Waiting Period independently and it is calculated beginning on the Insured Person's Effective Date of coverage.

Notice of the Availability of Language Assistance Services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Spanish

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

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Vietnamese

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

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

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。Japanese

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

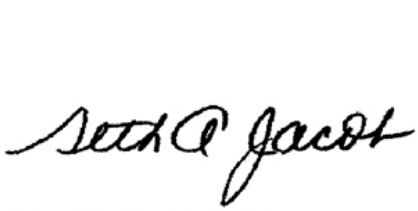
ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। Punjabi

ជេរវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

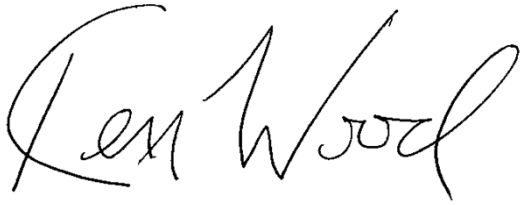
خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Hmong

IN WITNESS WHEREOF, Blue Shield of California Life & Health Insurance Company, through its duly authorized Officers, execute this Policy, to take effect on the Insured Person's Effective Date.



Seth A. Jacobs, Secretary
Blue Shield of California Life & Health Insurance Company



Ken Wood
President & Chief Executive Officer
Blue Shield of California Life & Health Insurance Company

Vision Customer Service Telephone Numbers:

Blue Shield Life
Vision Plan Administrator
1-877-601-9083

Blue Shield Life may be reached by calling 1-800-431-2809.

Vision Customer Service Correspondence Addresses:

Blue Shield Life
Vision Plan Administrator
Vision Customer Service
P. O. Box 25208
Santa Ana, CA 92799-5208

Claims for all other Covered Services should be sent to:
Blue Shield Life
P. O. Box 25208
Santa Ana, CA 92799-5208

Notes

Notes

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