



Dental PPO SmileSM Basic Voluntary Plan

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

Summary of Benefits

Dental PPO Plan

Member Calendar Year Deductible (Dental Plan Deductible)	Deductible Responsibility	
	Participating Dentists	Non-Participating Dentists
The deductible applies to all covered Services incurred except for Diagnostic and Preventive Services and Enhanced Dental Benefits for Pregnant Women provided by Participating Dentists.	\$75 per Member / \$225 per Family	

Maximum Calendar Year Payment	Maximum Blue Shield Payment	
	Participating Dentists	Non-Participating Dentists
For all covered Services The Plan pays up to the maximum payment amount as listed for covered Services and supplies.	\$1,000 per Member ¹	\$750 per Member

Covered Services and Supplies	Blue Shield Payment Percentage	
	Participating Dentists	Non-Participating Dentists
Diagnostic and Preventive Services	100%	50%
Enhanced Dental Benefits for Pregnant Women	100%	100%
Basic Services	50%	50%
Major Services	50%	50%

¹The Plan pays up to this maximum payment amount for all covered Services and supplies received from any combination of Participating and Non-Participating Dentists.

This Summary of Benefits is a supplement to, and a part of the Dental PPO Evidence of Coverage (EOC). The provisions contained in this Summary of Benefits are described in detail in the EOC.

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

PRECERTIFICATION OF DENTAL BENEFITS PROGRAM

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

COVERED SERVICES AND SUPPLIES

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

DIAGNOSTIC AND PREVENTIVE SERVICES

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

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

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

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

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

X-rays:

Bitewing film not more than once in any period of 6 consecutive months. Full mouth series (includes 10 to 14 periapical x-rays and supplementary bitewing films) not more than once in any period of 24

consecutive months. In applying this 24 month limitation, a panoramic x-ray shall be considered a full mouth series.

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

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

ENHANCED DENTAL BENEFITS FOR PREGNANT WOMEN

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

1. One additional routine adult prophylaxis including periodontal prophylaxis for gingivitis for women during pregnancy (Note: This prophylaxis is in addition to the prophylaxis provided under *DIAGNOSTIC AND PREVENTIVE SERVICES*); and
2. One periodontal maintenance visit if warranted by a history of periodontal treatment*; and
3. One course (up to 4 quadrants) of periodontal scaling and root planing for women during pregnancy with a documented existing periodontal condition*.

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

BASIC SERVICES

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

Palliative — Emergency treatment for relief of pain.

Restorative Dentistry — 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.

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

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

MAJOR SERVICES

Note: For the following Major Services, a 12-month waiting period may apply. This waiting period may be waived if any of the following documented conditions exist:

- Acute pulpal necrosis requiring immediate root canal;
- Acute pulpal/periodontal abscess requiring incision & drainage or removal of an erupted tooth;
- Acute periodontal abscess requiring emergency periodontal procedures;
- A tooth that is undergoing restoration that was begun as a filling (under Basic Services) is now required to have a cast crown (under Major Services) placed, due to the extent of decay/fracture found during the course of its restoration.

The Plan and a Dental Plan Administrator reserve the right to review the submitted documentation for a coverage determination. See your Group Administrator or contact Customer Service for more information.

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

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

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

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).

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



Blue Shield of California Life & Health Insurance Company

Outpatient Prescription Drug Benefit Rider

Insurance Certificate Outpatient Prescription Drug Benefit Rider

Summary of Benefits

Insured Calendar Year Brand Name Drug Deductible	Insured Responsibility	
	Participating Pharmacy	Non-Participating Pharmacy
Per Insured	\$250	
Applicable to all covered Brand Name Drugs, including Home Self-Administered Injectables		
<u>Benefit</u>	<u>Insured Copayment</u>	
Retail prescriptions	Participating Pharmacy	Non-Participating Pharmacy
Formulary Generic Drugs	\$10	Following submission of a claim, 25% plus the applicable Copayment for Participating Pharmacy
Formulary Brand Name Drugs	\$30	Following submission of a claim, 25% plus the applicable Copayment for Participating Pharmacy
Non-Formulary Brand Name Drugs	\$50	Following submission of a claim, 25% plus the applicable Copayment for Participating Pharmacy
Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs	30% of the Blue Shield negotiated pharmacy contracted rate for each prescription	Not covered

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Mail service prescriptions		
Mail Service Formulary Generic Drugs	\$20	Following submission of a claim, 25% plus the applicable Copayment for Participating Pharmacy
Mail Service Formulary Brand Name Drugs	\$60	Following submission of a claim, 25% plus the applicable Copayment for Participating Pharmacy
Mail Service Non-Formulary Brand Name Drugs	\$100	Following submission of a claim, 25% plus the applicable Copayment for Participating Pharmacy
Mail Service Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs	Not covered	Not covered

This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Part D premiums.

Outpatient Prescription Drug Benefit

The following prescription drug benefit is separate from the medical Benefits provided pursuant to the Blue Shield Life Group Policy. The Coordination of Benefits provision does not apply to this Outpatient Prescription Drug Benefit Rider; however, the general provisions and exclusions of the Blue Shield Life Group Policy shall apply.

Benefits are provided for Outpatient prescription Drugs, which meet all of the requirements specified in this Rider, are prescribed by a Physician, and are obtained from a licensed Pharmacy. Drug coverage is based on the use of Blue Shield's Outpatient Drug Formulary, which is updated on an ongoing basis by Blue Shield's Pharmacy and Therapeutics Committee. Select Drugs and Drug dosages and most Home Self-Administered Injectables require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available. Your Physician may request prior authorization from Blue Shield.

Coverage for selected Drugs may be limited to a specific quantity as described in "Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill".

Outpatient Drug Formulary

Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year.

Insureds may call Blue Shield's Customer Service department at the number listed on their Blue Shield Life Identification Card to inquire if a specific drug is included in the Formulary. The Customer Service department can also provide Insureds with a printed copy of the Formulary. Insureds may also access the Formulary through the web site at <http://www.mylifepath.com>.

Definitions

Brand Name Drugs — FDA approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name.

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes, (3) pen delivery systems for the administration of Insulin as Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets), (5) oral contraceptives and diaphragms, and (6) smoking cessation Drugs which require a prescription – coverage limited to one 24-week course of treatment per lifetime, (7) inhalers

and inhaler spacers for the management and treatment of asthma.

Note: No prescription is necessary to purchase the items shown in (2), (3) and (4) above; however, in order to be covered these items must be ordered by your Physician.

Formulary — A comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Prescription Drug Program which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically. If not otherwise excluded, the Formulary includes all Generic Drugs. Benefits are provided for Formulary Drugs.

Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) as therapeutic equivalent to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) cost less than the Brand Name Drug equivalent.

Home Self-Administered Injectables — Home Self-Administered Injectable medications are defined as those Drugs which are Medically Necessary, administered more often than once a month by patient or family member, administered subcutaneously or intramuscularly, deemed safe for self-administration as determined by Blue Shield's Pharmacy and Therapeutics Committee, prior authorized by Blue Shield, and obtained from a Blue Shield Specialty Pharmacy. Intravenous (IV) medications (i.e. those medications administered directly into a vein) are not considered Home Self-Administered Injectable Drugs. Home Self-Administered Injectables are listed in Blue Shield's Outpatient Drug Formulary.

Non-Formulary Drugs — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as being duplicative or as having preferred Formulary Drug alternatives available. Benefits are provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

Non-Participating Pharmacy — a pharmacy which does not participate in the Blue Shield Pharmacy Network.

Participating Pharmacy — a pharmacy which participates in the Blue Shield Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Subscribers. Note: the Mail Service Pharmacy is a Participating Pharmacy.

To select a Participating Pharmacy, Insureds may go to <http://www.mylifepath.com> or call the toll-free Customer Service number on the Blue Shield Life Identification Card.

Specialty Pharmacy Network – select Participating Pharmacies contracted by Blue Shield to provide covered Home Self-Administered Injectables. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Home Self-Administered Injectables.

To select a Specialty Pharmacy, you may go to <http://www.mylifepath.com> or call the toll-free Customer

Service number on your Blue Shield Life Identification Card.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain prescription Drugs at a Participating Pharmacy, the Insured must present his Blue Shield Life Identification Card. Note: Except for covered emergencies, claims for Drugs obtained without using the Blue Shield Life Identification Card will be denied.

Benefits are provided for Home Self-Administered Injectables only when obtained from a Blue Shield Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Home Self-Administered Injectables that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary from a Non-Participating Pharmacy.

The Insured is responsible for paying the applicable Copayment for each new and refill prescription Drug. The pharmacist will collect from the Insured the applicable Copayment at the time the Drugs are obtained.

For diaphragms, the Formulary Brand Name Copayment applies.

If the Participating Pharmacy contracted rate charged by the Participating Pharmacy is less than or equal to the Insured's Copayment, the Insured will only be required to pay the Participating Pharmacy's contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Name Drug Deductible, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Blue Shield Participating Pharmacy at the time the Drug is obtained, until the Brand Name Drug Deductible is satisfied.

If the Insured requests a Brand Name Drug when a Generic Drug equivalent is available, and the Brand Name Drug Deductible has been satisfied (when applicable), the Insured is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment.

If the prescription specifies a Brand Name Drug and the prescribing Physician has written "Dispense As Written" or "Do Not Substitute" on the prescription, or if a Generic Drug equivalent is not available, the Insured is responsible for paying the applicable Brand Name Drug Copayment.

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

To obtain prescription Drugs at a Non-Participating Pharmacy, the Insured must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The Insured will be reimbursed as shown on the Summary of Benefits based

on the price actually paid for the Drugs, minus the Insured's applicable Copayment or Coinsurance. Claims must be received within 1 year from the date of service to be considered for payment.

When Drugs are obtained at a Non-Participating Pharmacy for a covered emergency, including Drugs for emergency contraception, the Insured must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim Form noting "emergency request" on the form to Blue Shield Pharmacy Services - Emergency Claims, P. O. Box 7168, San Francisco, CA 94120. The Insured will be reimbursed the purchase price of covered prescription Drug(s) minus any applicable Copayment(s) or Coinsurance. Claim forms may be obtained from the Blue Shield Service Center. Claims must be received within 1 year from the date of service to be considered for payment.

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

For the Insured's convenience, when Drugs have been prescribed for a chronic condition and the Insured's medication dosage has been stabilized, he may obtain the Drug through Mail Service Prescription Drug Program. Prior to using this Mail Service Program, the Insured must have received the same medication and dosage through the Blue Shield pharmacy network for at least two months. The Insured should submit the applicable mail service Copayment, order form and his Blue Shield Life Identification number to the address indicated on the mail service envelope. Insureds should allow up to 14 days to receive the Drugs. The Insured's Physician must indicate a prescription quantity which is equal to the amount to be dispensed. Home Self-Administered Injectables, except for Insulin, are not available through the Mail Service Prescription Drug Program.

The Insured is responsible for the applicable Mail Service Prescription Drug Copayment for each new or refill prescription Drug.

If the Participating Pharmacy contracted rate is less than or equal to the Insured's Copayment, the Insured will only be required to pay the Participating Pharmacy contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Name Drug Deductible, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Brand Name Drug to the Mail Service Pharmacy prior to your prescription being sent to you. To obtain the Participating Pharmacy contracted rate amount, please contact the Mail Service Pharmacy at 1-866-346-7200. The TTY telephone number is 1-866-346-7197.

If the Insured requests a Mail Service Brand Name Drug when a Mail Service Generic Drug is available, and the Brand Name Drug Deductible has been satisfied, the Insured is responsible for paying the difference between

the contracted rate for the Mail Service Brand Name Drug and its Mail Service Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment.

If the prescription specifies a Mail Service Brand Name Drug and the prescribing Physician has written "Dispense As Written" or "Do Not Substitute" on the prescription, or if a Mail Service Generic Drug equivalent is not available, the Insured is responsible for paying the applicable Mail Service Brand Name Drug Copayment.

Prior Authorization Process for Select Formulary and Non-Formulary Drugs and Most Home Self-Administered Injectables

Select Formulary Drugs, as well as most Home Self-Administered Injectables may require prior authorization for Medical Necessity. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective. Your Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within five business days or within 72 hours for an expedited review.

Limitation on Quantity of Drugs that may be Obtained Per Prescription or Refill

1. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee.
2. Mail Service Prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Insured's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply.
3. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

Exclusions

No benefits are provided under the Outpatient Prescription Drug Benefit for the following (please note, certain services excluded below may be covered under other benefits/portions of your Certificate - you should refer to the

applicable section to determine if drugs are covered under that Benefit):

1. Any Drug provided or administered while the Insured is an Inpatient, or in a Physician's office (see the Professional (Physician) Benefits and Hospital Benefits sections of your Certificate);
2. Take home Drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Benefits and Skilled Nursing Facility Benefits sections of your Certificate);
3. Drugs (except as specifically listed as covered under this Outpatient Prescription Drug Rider), which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;
4. Drugs for which the Insured is not legally obligated to pay, or for which no charge is made;
5. Drugs that are considered to be experimental or investigational;
6. Medical devices or supplies except as specifically listed as covered herein (see the Prosthetic Appliances Benefits, Durable Medical Equipment Benefits and Orthotics Benefits sections of your Certificate);
7. Blood or blood products (See the Hospital Benefits section of your Certificate);
8. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
9. Dietary or Nutritional Products (see the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products sections of your Certificate);
10. Injectable drugs which are not self-administered, and all injectable drugs for the treatment of infertility. Other injectable medications may be covered under the Home

Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits and Family Planning Benefits of the Plan;

11. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;
12. Drugs when prescribed for smoking cessation purposes (over the counter or by prescription), except to the extent that smoking cessation prescription drugs are specifically listed as covered under the "Drugs" definition in this benefit description;
13. Contraceptive devices (except diaphragms), injections and implants;
14. Compounded medications if: (1) there is a medically appropriate Formulary alternative, or, (2) there are no FDA-approved indications. Compounded medications that do not include at least one Drug, as defined, are not covered;
15. Replacement of lost, stolen or destroyed prescription Drugs;
16. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to an Insured enrolled in a Hospice Program through a Participating Hospice Agency;
17. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;
18. Drugs obtained from a Pharmacy not licensed by the National Association of Boards of Pharmacies, unless Medically Necessary for a covered Emergency;
19. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;
20. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.

Please be sure to retain this document. It is not a policy but is a part of your *Certificate of Insurance*.

Domestic Partner Supplement

Supplement to your Blue Shield Evidence of Coverage

Your employer has elected to establish Domestic Partner eligibility requirements as described in this Supplement. The following changes have been made to your Evidence of Coverage:

1. Under the Definitions section of your Evidence of Coverage, the definition of Domestic Partner is changed to read as follows:

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

1. Both partners are (a) 18 years of age or older and (b) of the same or different sex;
2. The partners share (a) an intimate and committed relationship of mutual caring and (b) the same principal residence;

3. The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

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

Please be sure to retain this document. It is not a contract but is a part of your Evidence of Coverage.