# Dental HMO Plan

**Evidence of Coverage and Health Service Agreement**

Individual and Family Plan



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# Blue Shield of California
# Individual and Family
# Dental HMO Plan

## Evidence of Coverage and
## Health Service Agreement

This AGREEMENT is issued by California Physicians' Service d/b/a Blue Shield of California ("Blue Shield"), a not for profit health care service Plan, to the Subscriber whose identification cards are issued with this Agreement. In consideration of statements made in the application and timely payment of Dues, Blue Shield of California agrees to provide the Benefits of this Agreement.

**NOTICE TO NEW SUBSCRIBERS**

Please read this Service Agreement carefully. If you have any questions, contact Blue Shield. You may surrender this Agreement by delivering or mailing it with the identification cards, within ten (10) days from the date it is received by you, to BLUE SHIELD OF CALIFORNIA, 601 12th STREET, OAKLAND, CALIFORNIA 94607. Immediately upon such delivery or mailing, the Agreement shall be deemed void from the beginning, and Dues paid will be refunded.

**IMPORTANT!**

No 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 Agreement 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 Agreement.

**IMPORTANT!**

If you opt to receive dental services that are not Covered Services under this Plan, a participating Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-888-256-3650 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.

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## Summary of Benefits

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

# Blue Shield of California DHMO Plan

### Summary of Benefits

| ADA Code | Procedure | Member Copayment |
|---|---|---|
| | **Diagnostic (exams and x-rays)** | |
| D0120 | Periodic oral evaluation | You pay nothing |
| D0140 | Limited oral evaluation – problem focused | You pay nothing |
| D0145 | Oral evaluation for a patient under three years of age | You pay nothing |
| D0150 | Comprehensive oral evaluation | You pay nothing |
| D0160 | Detailed and extensive oral evaluation – problem focused | You pay nothing |
| D0170 | Re-evaluation – limited, problem focused (not post-operative visit) | You pay nothing |
| D0180 | Comprehensive periodontal evaluation | You pay nothing |
| D0190 | Screening of a patient | You pay nothing |
| D0191 | Assessment of a patient | You pay nothing |
| D0210 | Intraoral radiographs – complete series (including bitewings) (once every 36 months) | You pay nothing |
| D0220 | Intraoral periapical radiograph – first film | You pay nothing |
| D0230 | Intraoral periapical radiograph – each additional film | You pay nothing |
| D0240 | Intraoral occlusal radiograph | You pay nothing |
| D0250 | Extraoral – first film | You pay nothing |
| D0260 | Extraoral – each additional film | You pay nothing |
| D0270 | Bitewing radiograph – single film | You pay nothing |
| D0272 | Bitewing radiograph – two films | You pay nothing |
| D0273 | Bitewings – three films | You pay nothing |
| D0274 | Bitewing radiograph – four films | You pay nothing |
| D0277 | Vertical bitewings – 7 to 8 films | You pay nothing |
| D0330 | Panoramic film (once every 36 months) | You pay nothing |
| D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | You pay nothing |
| D0460 | Pulp vitality tests | You pay nothing |
| D0470 | Diagnostic casts | You pay nothing |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D0601 | Caries risk assessment and documentation, with a finding of low risk | You pay nothing |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk | You pay nothing |
| D0603 | Caries risk assessment and documentation, with a finding of high risk | You pay nothing |
| | **Preventive (cleanings and fluoride)** | |
| D1110 | Prophylaxis (adult) every 6 months | You pay nothing |
| D1120 | Prophylaxis (child) every 6 months | You pay nothing |
| D1206 | Topical fluoride varnish | You pay nothing |
| D1208 | Topical application of fluoride – child(ren) under the age of 16 | You pay nothing |
| D1330 | Oral hygiene instruction | You pay nothing |
| D1351 | Sealant per tooth | You pay nothing |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient – permanent tooth child through age 18 | You pay nothing |
| D1510 | Space maintainer – fixed – unilateral | $55 |
| D1516 | Space maintainer – fixed – bilateral, maxillary | $55 |
| D1517 | Space maintainer – fixed – bilateral, mandibular | $55 |
| D1520 | Space maintainer – removable – unilateral | $55 |
| | | |
| D1526 | Space maintainer – removable – bilateral, maxillary | $55 |
| D1527 | Space maintainer – removable – bilateral, mandibular | $55 |
| D1550 | Recementation of space maintainer | $17 |
| D1555 | Removal of fixed space maintainer | $13 |
| D1575 | Distal shoe space maintainer – fixed – unilateral (under age 6) once per lifetime | $5 |
| | **Minor restorative (fillings)** | |
| D2140 | Amalgam – one surface, primary or permanent | $15 |
| D2150 | Amalgam – two surfaces, primary or permanent | $18 |
| D2160 | Amalgam – three surfaces, primary or permanent | $21 |
| D2161 | Amalgam – four or more surfaces, primary or permanent | $24 |
| D2330 | Resin based composite – one surface, anterior | $18 |
| D2331 | Resin based composite – two surfaces, anterior | $23 |
| D2332 | Resin based composite – three surfaces, anterior | $27 |
| D2335 | Resin based composite – four or more surfaces or involving incisal angle, anterior | $60 |
| D2390 | Resin based composite crown, anterior | $50 |
| D2391 | Resin base composite – one surface, posterior | $15 |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D2392 | Resin base composite – two surfaces, posterior | $19 |
| D2393 | Resin base composite – three surfaces, posterior | $24 |
| D2394 | Resin base composite – four or more surfaces, posterior | $29 |
| | **Major restorative (crowns)** | |
| D2542 | Onlay – metallic – two surfaces [1] | $185 |
| D2543 | Onlay – metallic – three surfaces [1] | $200 |
| D2544 | Onlay – metallic – four or more surfaces [1] | $215 |
| D2642 | Onlay – porcelain / ceramic two surfaces [1] | $250 |
| D2643 | Onlay – porcelain / ceramic three surfaces [1] | $275 |
| D2644 | Onlay – porcelain / ceramic four or more surfaces [1] | $300 |
| D2662 | Onlay – resin based composite two surfaces [1] | $160 |
| D2663 | Onlay – resin based composite three surfaces | $180 |
| D2664 | Onlay – resin based composite four or more surfaces [1] | $200 |
| D2710 | Crown – resin based composite (indirect) | $100 |
| D2720 | Crown – resin with high noble metal [1] | $100 |
| D2721 | Crown – resin with predominantly base metal [1] | $100 |
| D2722 | Crown – resin with noble metal [1] | $100 |
| D2740 | Crown - porcelain/ceramic [1] | $300 |
| D2750 | Crown - porcelain fused to high noble metal [1] | $300 |
| D2751 | Crown – porcelain fused to predominantly base metal [1] | $300 |
| D2752 | Crown – porcelain fused to noble metal [1] | $300 |
| D2780 | Crown – ¾ cast high noble metal | $300 |
| D2781 | Crown – ¾ cast predominantly base metal | $300 |
| D2782 | Crown – ¾ cast noble metal | $300 |
| D2790 | Crown – full cast high noble metal [1] | $300 |
| D2791 | Crown – full cast predominantly base metal [1] | $300 |
| D2792 | Crown – full cast noble metal [1] | $300 |
| D2910 | Recement inlay onlay or partial coverage restoration | You pay nothing |
| D2915 | Recement cast or prefabricated post and core | You pay nothing |
| D2920 | Recement crown | You pay nothing |
| D2930 | Prefabricated stainless steel crown primary tooth | $35 |
| D2931 | Prefabricated stainless steel crown – permanent tooth | $50 |
| D2932 | Prefabricated resin crown | $40 |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D2934 | Prefabricated esthetic coated stainless steel crown -primary tooth | $35 |
| D2940 | Protective restoration | $20 |
| D2950 | Core buildup, including any pins | $20 |
| D2951 | Pin retention – per tooth, in addition to restoration | $20 |
| D2952 | Post and core in addition to crown, indirectly fabricated | $60 |
| D2953 | Each additional indirectly fabricated post – same tooth | $30 |
| D2954 | Prefabricated post and core in addition to crown | $60 |
| D2957 | Each additional prefabricated post – same tooth | $35 |
| D2980 | Crown repair by report | $50 |
| | **Periodontics (gum disease)** | |
| D4210 | Gingivectomy/gingivoplasty four or more contiguous teeth or tooth bounded spaces – per quadrant | $150 |
| D4211 | Gingivectomy/gingivoplasty one to three contiguous teeth or tooth bounded spaces – per quadrant | $50 |
| D4240 | Gingival flap procedure including root planing four or more teeth – per quadrant | $135 |
| D4241 | Gingival flap procedure including root planing – one to three teeth – per quadrant | $70 |
| D4260 | Osseous surgery (including flap entry and closures) – four or more contiguous teeth or tooth bounded spaces – per quadrant | $265 |
| D4261 | Osseous surgery (including flap entry and closures) – one to three contiguous teeth or tooth bounded spaces – per quadrant | $140 |
| D4263 | Bone replacement graft – first site in quadrant | $105 |
| D4264 | Bone replacement graft – each additional site in quadrant | $75 |
| D4266 | Guided tissue regeneration – resorbable barrier – per site | $145 |
| D4267 | Guided tissue regeneration – non-resorbable barrier – per site (includes membrane removal) | $175 |
| D4270 | Pedicle soft tissue graft procedure | $155 |
| D4273 | Subepithelial connective tissue graft procedure – per tooth | $220 |
| D4341 | Periodontal scaling and root planing – four or more teeth / per quadrant | $55 |
| D4342 | Periodontal scaling and root planing – one to three teeth / per quadrant | $25 |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (11 years of age and older) once per 12 months | $5 |
| D4355 | Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit | $40 |
| D4910 | Periodontal maintenance | $30 |
| | **Prosthetics removable (dentures)** | |
| D5110 | Complete denture – maxillary | $400 |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D5120 | Complete denture – mandibular | $400 |
| D5130 | Immediate denture – maxillary | $400 |
| D5140 | Immediate denture – mandibular | $400 |
| D5211 | Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth) | $325 |
| D5212 | Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth) [1] | $325 |
| D5213 | Maxillary partial – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [1] | $375 |
| D5214 | Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) [1] | $375 |
| D5225 | Maxillary partial denture – flexible base (including any clasps, rests, and teeth) [1] | $375 |
| D5226 | Mandibular partial denture – flexible base (including any clasps, rests, and teeth) [1] | $375 |
| D5282 | Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary | $250 |
| D5283 | Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular | $250 |
| D5410 | Adjust complete or partial denture – maxillary | $8 |
| D5411 | Adjust complete denture – mandibular | $8 |
| D5421 | Adjust partial denture – maxillary | $8 |
| D5422 | Adjust partial denture – mandibular | $8 |
| D5511 | Denture repair – broken complete denture base, mandibular | $30 |
| D5512 | Denture repair - broken complete denture base, maxillary | $30 |
| D5520 | Denture repair – missing or broken teeth – complete denture – each tooth | $30 |
| D5611 | Denture repair – resin partial denture base, mandibular | $30 |
| D5612 | Denture repair – resin partial denture base, maxillary | $30 |
| D5621 | Denture repair – cast partial framework, mandibular | $35 |
| D5622 | Denture repair – cast partial framework, maxillary | $35 |
| D5630 | Repair or replace broken retentive/clasping materials – per tooth | $30 |
| D5640 | Denture repair – broken tooth – per tooth | $30 |
| D5650 | Add tooth to existing partial denture | $35 |
| D5660 | Add clasp to existing partial denture | $45 |
| D5670 | Replace all teeth and acrylic on cast framework – maxillary | $195 |
| D5671 | Replace all teeth and acrylic on cast framework – mandibular | $195 |
| D5710 | Denture rebase – complete maxillary | $55 |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D5711 | Denture rebase – complete mandibular | $55 |
| D5720 | Denture rebase – partial maxillary | $55 |
| D5721 | Denture rebase – partial mandibular | $55 |
| D5730 | Reline complete maxillary denture (chairside) [2] | $40 |
| D5731 | Reline complete mandibular denture (chairside) [2] | $40 |
| D5740 | Reline maxillary partial denture (chairside) [2] | $40 |
| D5741 | Reline mandibular partial denture (chairside) [2] | $40 |
| D5750 | Reline complete maxillary denture (laboratory) [2] | $60 |
| D5751 | Reline complete mandibular denture (laboratory) [2] | $60 |
| D5760 | Reline maxillary partial denture (laboratory) [2] | $60 |
| D5761 | Reline mandibular partial denture (laboratory) [2] | $60 |
| D5850 | Tissue conditioning – maxillary | $35 |
| D5851 | Tissue conditioning – mandibular | $35 |
| | **Implants** | |
| D6010 | Surgical placement of implant body: endosteal implant | $1,375 |
| D6056 | Prefabricated abutment – includes placement | $500 |
| D6057 | Custom abutment – includes placement | $600 |
| D6058 | Abutment supported porcelain/ceramic crown | $1,250 |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | $1,250 |
| D6060 | Abutment supported porcelain fused to metal crown (predominately base metal) | $1,150 |
| D6061 | Abutment supported porcelain fused to metal crown (noble metal) | $900 |
| D6062 | Abutment supported cast metal crown (high noble metal) | $1,000 |
| D6063 | Abutment supported cast metal crown (predominately base metal) | $962 |
| D6064 | Abutment supported cast metal crown (noble metal) | $825 |
| D6065 | Implant supported porcelain/ceramic crown | $1,250 |
| D6066 | Implant supported porcelain fused to metal crown | $1,250 |
| D6067 | Implant supported metal crown | $1,300 |
| D6080 | Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of | $225 |
| D6090 | Repair implant supported prosthesis, by report | $288 |
| D6092 | Recement implant/abutment supported crown | $109 |
| D6094 | Abutment supported crown – titanium | $913 |
| D6095 | Repair implant abutment, by report | $300 |
| D6096 | Remove broken implant retaining screw | You pay nothing |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D6100 | Implant removal, by report | $500 |
| | **Bridge abutments or pontics** | |
| D6205 | Pontic – indirect resin based composite | $165 |
| D6210 | Pontic – cast high noble metal [1] | $300 |
| D6211 | Pontic – case predominantly base metal [1] | $300 |
| D6212 | Pontic – cast noble metal [1] | $300 |
| D6214 | Pontic – cast titanium metal [1] | $300 |
| D6240 | Pontic – porcelain fused to high noble metal [1] | $300 |
| D6241 | Pontic – porcelain fused to predominantly base metal [1] | $300 |
| D6242 | Pontic – porcelain fused to noble metal [1] | $300 |
| D6245 | Pontic – porcelain / ceramic [1] | $300 |
| D6250 | Pontic – resin with high noble metal [1] | $381 |
| D6251 | Pontic – resin with predominantly base metal [1] | $368 |
| D6252 | Pontic – resin with high noble metal [1] | $374 |
| D6545 | Retainer – cast metal for resin bonded fixed prosthesis [1] | $130 |
| D6548 | Retainer – porcelain / ceramic for resin bonded fixed prosthesis | $145 |
| D6608 | Onlay – porcelain / ceramic two surfaces [1] | $200 |
| D6609 | Onlay – porcelain / ceramic three surfaces [1] | $200 |
| D6610 | Onlay – cast high noble metal – two surfaces [1] | $200 |
| D6611 | Onlay – cast high noble metal – three or more surfaces [1] | $200 |
| D6612 | Onlay – cast predominantly base metal – two surfaces [1] | $200 |
| D6613 | Onlay – cast predominantly base metal – three or more surfaces [1] | $200 |
| D6614 | Onlay – cast noble metal – two surfaces [1] | $200 |
| D6615 | Onlay – cast noble metal – three or more surfaces [1] | $200 |
| D6634 | Onlay – titanium [1] | $129 |
| D6710 | Bridge retainer – crown – indirect resin based composite [1] | $200 |
| D6720 | Bridge retainer – crown – resin with high noble metal [1] | $300 |
| D6721 | Bridge retainer – crown – resin with predominantly base metal [1] | $100 |
| D6722 | Bridge retainer – crown – resin with noble metal [1] | $100 |
| D6740 | Bridge retainer – crown – porcelain / ceramic [1] | $300 |
| D6750 | Bridge retainer – crown – porcelain/fused to high noble metal [1] | $300 |
| D6751 | Bridge retainer – crown – porcelain / fused to predominantly base metal [1] | $300 |
| D6752 | Bridge retainer – crown – porcelain / fused to noble metal [1] | $300 |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D6780 | Bridge retainer – crown – ¾ cast high noble metal [1] | $300 |
| D6781 | Bridge retainer – crown – ¾ cast predominantly base metal [1] | $300 |
| D6782 | Bridge retainer – crown – ¾ cast noble metal [1] | $300 |
| D6783 | Bridge retainer – crown – ¾ porcelain / ceramic (anterior and premolar teeth only) [1] | $300 |
| D6790 | Bridge retainer – crown – full cast high noble metal [1] | $300 |
| D6791 | Bridge retainer – crown – full cast predominantly base metal [1] | $300 |
| D6792 | Bridge retainer – crown – full cast noble metal [1] | $300 |
| D6930 | Recement fixed partial denture | You pay nothing |
| D6980 | Fixed partial denture repair, by report | $20 |
| | **Endodontics (root canals)** | |
| D3110 | Pulp cap (direct) excluding final restoration | $20 |
| D3120 | Pulp cap (indirect) excluding final restoration | $25 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament | $35 |
| D3310 | Endodontic therapy – anterior tooth (excluding final restoration) | $155 |
| D3320 | Endodontic therapy – premolar tooth (excluding final restoration) | $235 |
| D3330 | Endodontic therapy – molar tooth (excluding final restoration) | $290 |
| D3331 | Treatment of root canal obstruction; non-surgical access | You pay nothing |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | $85 |
| D3346 | Retreatment of previous root canal – anterior | $245 |
| D3347 | Retreatment of previous root canal – bicuspid | $295 |
| D3348 | Retreatment of previous root canal – molar | $365 |
| D3410 | Apicoectomy / periradicular surgery – anterior | $240 |
| D3421 | Apicoectomy / periradicular surgery – premolar(first root) | $240 |
| D3425 | Apicoectomy / periradicular surgery – molar (first root) | $250 |
| D3426 | Apicoectomy / periradicular surgery – (each additional root) | $110 |
| D3430 | Retrograde filling – per root | $90 |
| D3450 | Root amputation – per root | $110 |
| D3920 | Hemisection (including any root removal; not including root canal therapy) | $120 |
| D3950 | Canal preparation and fitting of preformed dowel or post | You pay nothing |
| | **Oral surgery** | |
| D7111 | Extraction of coronal remnants - primary tooth | $15 |
| D7140 | Extraction of erupted tooth or exposed root | $34 |
| D7210 | Surgical removal of erupted tooth | $70 |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D7220 | Removal of impacted tooth – soft tissue | $85 |
| D7230 | Removal of impacted tooth – partial bony | $105 |
| D7240 | Removal of impacted tooth – complete bony | $125 |
| D7241 | Removal of impacted tooth – complete bony with unusual surgical complications | $95 |
| D7250 | Surgical removal of residual tooth roots | $75 |
| D7260 | Oroantral fistula closure | $280 |
| D7286 | Biopsy of oral tissue – soft [3] | $110 |
| D7287 | Exfoliative cytological sample collection | $35 |
| D7288 | Brush biopsy – transepiteliel sample collection | $35 |
| D7310 | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | $70 |
| D7311 | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | $50 |
| D7320 | Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | $85 |
| D7321 | Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | $43 |
| D7471 | Removal of lateral exostosis maxilla or mandible | $140 |
| D7472 | Removal of torus palatinus | $140 |
| D7473 | Removal of torus mandibularis | $140 |
| D7510 | Incision & drainage of abscess – intraoral soft tissue | $55 |
| D7511 | Incision & drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple facial spaces) | $69 |
| D7550 | Partial ostectomy/sequestrectomy for removal of non-vital bone | $125 |
| D7960 | Frenectomy/Frenotomy – separate procedure | $120 |
| D7963 | Frenuloplasty | $120 |
| D7970 | Excision of hyperplastic tissue – per arch [3] | $176 |
| D7971 | Excision of pericoronal gingival [3] | $80 |
| | **Adjunctive General Services** | |
| D9110 | Palliative (emergency) treatment of dental pain – minor procedure [4] | $28 |
| D9120 | Fixed partial denture sectioning | $20 |
| D9210 | Local anesthesia not in conjunction with outpatient surgical procedures | You pay nothing |
| D9211 | Regional block anesthesia | You pay nothing |
| D9212 | Trigeminal division block anesthesia | You pay nothing |
| D9215 | Local anesthesia in conjunction with outpatient surgical procedures | You pay nothing |
| D9220 | General anesthesia – first 30 minutes | $90 |
| D9221 | General anesthesia – each additional 15 minutes | $35 |
| D9222 | Deep sedation/general anesthesia – first 15 minutes | You pay nothing |

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| ADA Code | Procedure | Member Copayment |
|---|---|---|
| D9239 | Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes | You pay nothing |
| D9241 | IV sedation – first 30 minutes | $100 |
| D9242 | IV sedation – each additional 15 minutes | $40 |
| D9310 | Consultation – diagnostic service provided by Dentist or physician other than requesting Dentist or physician | $0 |
| D9430 | Office visit for observation (during regularly scheduled hours) – no other services performed | $12 |
| D9440 | Office visit – after regularly scheduled hours | $40 |
| D9450 | Case presentation | You pay nothing |
| D9910 | Application of desensitizing medicament | $22 |
| D9944 | Occlusal guard – hard appliance, full arch | $115 |
| D9945 | Occlusal guard – soft appliance, full arch | $115 |
| D9946 | Occlusal guard – hard appliance, partial arch | $115 |
| D9942 | Repair and/or reline occlusal guard | $35 |
| D9951 | Occlusal – limited | $45 |
| D9952 | Occlusal adjustment – complete | $210 |
| | **Other** | |
| | Failed Appointment (without 24-hour notice) | $15 |
| | Sterilization surcharge | $5 |
| | **Orthodontics** [5,6,7]<br>Orthodontic treatment to correct malocclusion, limited to one continuous two-year course of treatment. There is a 12-month waiting period for these procedures. | |
| D8070 | Comprehensive Orthodontic treatment of the transitional dentition | $2,100 |
| D8080 | Comprehensive Orthodontic treatment of the adolescent dentition | $2, 350 |
| D8090 | Comprehensive Orthodontic treatment of the adult dentition | $2,650 |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development | $130 |
| D8670 | Periodic Orthodontic treatment visit (as part of contract) | You pay nothing |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | $225 |

[1] Precious and semi-precious metals, if used, will be charged to the patient at the additional cost of the metal. Porcelain on molar crowns is subject to an additional charge of $75.00.

[2] Denture relines, if done within six (6) months of the initial insertion of a denture are considered part of the original denture service and are included in the denture Copayment; denture relines after six (6) months of the initial insertion of a denture require the additional denture reline Copayment.

[3] Subscriber pays lab fees for biopsies and excisions.

[4] For an emergency oral exam with Palliative Treatment, if treatment includes a listed procedure, then regular Copayment applies.

[5] There is a 12 month waiting period for orthodontic services. 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.

[6] Full case fee includes consultation, treatment plan, tooth movement, and retention. Orthodontist may charge Members separately for records, limited to $250.00 per case.

[7] The Orthodontic Benefit is subject to all Plan limitations.

# Introduction to the Blue Shield Dental HMO Plan

Your interest in the Blue Shield Dental HMO (DHMO) Plan is appreciated. Blue Shield has been serving Californians for over 75 years, and we look forward to serving your dental care needs.

The Blue Shield DHMO Plan offers you a dental Plan with a wide choice of Plan Dental Providers. All Covered Services will be provided by or arranged through your Dental Center.

You will have the opportunity to be an active participant in your own dental care. Blue Shield DHMO Plan will help you make a personal commitment to maintaining and, where possible, improving your dental health status. Like you, we believe that maintaining a healthy lifestyle and preventing dental illness are as important as caring for your needs when dental problems arise.

Please review this booklet which summarizes the coverage and general provisions of the Blue Shield DHMO Plan.

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

If you have any questions regarding the information in this booklet, need assistance, or have any problems, you may contact your Dental Plan Member Services Department at: 1-888-256-3650.

# Conditions of Coverage

## Eligibility and Enrollment

1. To enroll and continue enrollment, a Member must meet all of the eligibility requirements of the Plan.
2. Enrollment of Subscribers or Dependents is not effective until Blue Shield of California approves an application and accepts the applicable Dues. Only Blue Shield's Underwriting Department can approve applications.
3. An applicant, upon completion and approval by Blue Shield of California of the application, is entitled to the Benefits of this Health Services Agreement (Agreement) upon the effective date.

   By completing an application, Subscribers and Dependents agree to cooperate with Blue Shield of California by providing, or providing access to, documents and other information that Blue Shield of California may request to corroborate the information that was provided in the application for coverage. If Subscribers or Dependents fail or refuse to provide these documents or information to Blue Shield of California, 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 Member contacts Blue Shield of California at the Member Service telephone number listed at the back of this booklet, to have the newborn child added to this Agreement 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 Member 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.

   Unless the child is enrolled, eligibility during the first 31 days includes treatment for injury or illness only, but does not include Well-baby care Benefits. Well-baby care Benefits are provided for enrolled children.
5. The effective date of Benefits for an adopted child will be the date the Subscriber, spouse, or Domestic partner has the right to control the child's health care, if the Member requests the child be added to this Agreement as a Dependent. Such request must be made within 31 days of the date the Member, 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 Subscriber, 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 Agreement as a Dependent, the Member must contact Blue Shield of California at the Customer Service telephone number listed at the back of this booklet. The Customer Service Department will advise the Subscriber 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 of California.

   Enrollment requests for an adopted child must be accompanied by evidence of the Subscriber's, 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 Member wishes to add a child placed for adoption as a Dependent 32 or more days after the date the Member, 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. See Paragraph 6 below.

Unless the child is enrolled, eligibility during the first 31 days includes treatment for injury or illness only, but does not include Well-baby care Benefits. Well-baby care Benefits are provided for enrolled children.

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

7. The Member can also add a Dependent under the age 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;

   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 Dues for the same coverage may be higher than the Dues you pay now.**

## Limitation of Enrollment

1. Members must be Residents of California, live or work in the Plan Service Area, and must select a Dental Provider who is located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by Blue Shield.

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 of marriage, or termination of domestic partnership from the Subscriber.

3. If the Subscriber seeks to add a Dependent under age 26 to the Plan other than a Dependent described in the paragraphs 3, 4, 5 or 6 of the section entitled Eligibility and Enrollment, this will result in Blue Shield of California recalculating or reassigning the appropriate Dues based on underwriting review of the Dependent.

## Duration of the Agreement

This Agreement shall be renewed upon receipt of prepaid Dues unless otherwise terminated as described herein. Renewal is subject to Blue Shield of California's right to amend this Agreement. Any change in Dues or Benefits, are effective after 60 days notice to the Subscriber's address of record with Blue Shield of California.

## Termination

This Agreement may be rescinded or terminated as follows:

1. Termination by the Subscriber:

   A Subscriber desiring to terminate this Agreement shall give Blue Shield of California 30 days written notice.

2. Termination by Blue Shield of California through cancellation:

   Blue Shield of California may cancel this Agreement immediately upon written notice for the following reasons:

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

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

   Rescission of this Agreement under this section will be permitted under California law, but rescission of this Agreement would not be permitted under Federal law.

   Cancellation of the Agreement under this section will terminate the Agreement effective as of the date that written notice of termination is mailed to the Subscriber. It is not retroactive to the original effective date of the Agreement.

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

   Blue Shield of California may cancel this Agreement upon 30 days written notice if the Subscriber moves out of California. See the section entitled "Transfer of Coverage" for additional information.

   Within 30 days of the notice of cancellation under sections 3 or 4, above, Blue Shield of California shall refund the prepaid Dues, if any, that Blue Shield of California determines will not have been earned as of the termination date. Blue Shield of California reserves the right to subtract from any such Dues refund any amounts paid by Blue Shield of California for Benefits paid or payable by Blue Shield of California after the termination date.

4. Termination by Blue Shield of California due to withdrawal of the Agreement from the market:

   Blue Shield of California may terminate this Agreement together with all like Agreements to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll on any other individual agreement without regard to health status-related factors.

5. Cancellation by Blue Shield for Subscriber's nonpayment of Dues:

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

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

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

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

### Renewal of the Agreement:

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

1. Nonpayment of Dues;
2. Fraud, misrepresentation, or omission;
3. Termination of plan type by Blue Shield of California;
4. Subscriber moves out of the Plan Service Area or the Member is no longer a Resident of California;
5. If a bona fide association arranged for the Subscriber's coverage under this Agreement, when that Subscriber's membership in the association ceases.

### Dues

Monthly Dues are as stated in the Appendix. Blue Shield of California offers a variety of options and methods by which you may pay your Dues. Please contact Member Service at 1-888-256-3650 to discuss these options or visit the Blue Shield of California internet site at http://www.blueshieldca.com.

Payments by mail are to be sent to:

c

Additional Dues may be charged in the event that a State or any other taxing authority imposes upon Blue Shield a tax or license fee that is calculated upon base Dues or Blue Shield's gross receipts or any portion of either. Dues increase according to the Subscriber's age, as stated in the Appendix. Dues may also increase from time to time as determined by Blue Shield of California. You will receive 60 days written notice of any changes in the monthly Dues for this Plan.

### Service Area

The Service Area of this Plan is identified in the Plan Dental Directory. Within the Service Area, Members will be entitled to receive all Covered Services specified in the Summary of Benefits. The Plan will not pay for Dental Care Services that are (a) not Covered Services, (b) not provided by, or referred and authorized by the Member's Dental Provider, and/or (c) not referred and authorized by the Plan, where applicable. The Member will be required to pay for the cost of such services received.

Within the Service Area, Members should contact their assigned Dental Provider for Emergency Services. Out-of-area Emergency Services are covered by the Plan subject to some limitations, as described in the section entitled "Choice of Dental Provider".

## Choice of Dental Provider

### Selecting a Dental Provider

A close Dentist - patient relationship is an important element that helps to ensure the best dental care. Each family is therefore required to select a Dental Provider at the time of enrollment. This decision is an important one because your Dental Provider will:

1. Help you decide on actions to maintain and improve your dental health.
2. Provide, coordinate and direct all necessary covered Dental Care Services.

3. Arrange referrals to Plan Specialists when required, including the prior Authorization you will need.
4. Authorize Emergency Services when appropriate.

The Dental Provider for each Subscriber must be located sufficiently close to the Subscriber's home or work address to ensure reasonable access to care, as determined by the Plan.

A Dental Provider must also be selected for a newborn or child placed for adoption if a covered Dependent.

If you do not select a Dental Provider at the time of enrollment or seek assistance from the Dental Plan Member Services Department within 15 days of the effective date of coverage, the Plan will designate a temporary Dental Provider for you and your Dependents, and notify you of the designated Dental Provider. This designation will remain in effect until you advise the Plan of your selection of a different Dental Provider.

## Changing Dental Providers

You or a Dependent may change Dental Providers without cause at the following times:

1. When your change in residence or work address makes it inconvenient to continue with the same Dental Provider;
2. One (1) other time during the Calendar Year.

If you want to change Dental Providers at any of the above times, you may call Dental Member Services at 1-888-256-3650. Before changing Dental Providers you must pay any outstanding Copayment balance owed to your existing Dental Provider. The change will be effective the first day of the month following notice of approval by the Plan.

If your Dental Provider ceases to be in a contracted Dental Plan Administrator's Provider Network, the Plan will notify you in writing. To ensure continuity of care you will temporarily be assigned to an alternate Dental Provider and you will be asked to select a new Dental Provider. If you do not select a new Dental Provider within the specified time, your alternate Dental Provider assignment will remain in effect until you notify the Plan of your desire to select a new Dental Provider.

## Continuity of Care by a Terminated Provider

Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age, or who have received Authorization from a now-terminated provider for dental surgery, or another dental procedure as part of a documented course of treatment, can request completion of care in certain situations with a provider who is leaving a contracted Dental Plan Administrator's Plan Provider Network. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

## Continuity of Care for New Members by Non-Contracting Providers

Newly covered Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age; or who have received Authorization from a provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracting provider who was providing services to the Member at the time the Member's coverage became effective under this Plan. Contact Member Services to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

## Payment of Providers

Blue Shield contracts with a Dental Plan Administrator to provide services to our Members. A monthly fee is paid to a contracted Dental Plan Administrator for each Member. This payment system includes incentives to a contracted Dental Plan Administrator to manage all Covered Services provided to Members in an appropriate manner consistent with this contract. If you want to know more about this payment system, contact Dental Plan Member Services at 1-888-256-3650 or talk to your Plan Provider.

A contracted Dental Plan Administrator is responsible for providing Covered Services and/or referring the Member to Plan Specialists and Plan Providers. Your Dental Provider must obtain Authorization from a contracted Dental Plan Administrator before referring you to providers outside of the Dental Center.

## Relationship with Your Dental Provider

The Dentist - patient relationship you establish with your Dental Provider is very important. The best effort of your Dental Provider will be used to ensure that all Medically Necessary and appropriate professional services are provided to you in a manner compatible with your wishes.

If your Dentist recommends procedures or treatment, which you refuse, or you and the Dental Provider fail to establish a satisfactory relationship, you may select a different Dental Provider. The Plan Member Services can assist you with this selection.

Your Dental Provider will advise you if they believe there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the recommended treatment or procedure, the Plan Member Services will assist you in the selection of another Dental Provider.

Repeated failures to establish a satisfactory relationship with a Dental Provider may result in termination of your coverage, but only after you have been given access to other available Dental Providers and have been unsuccessful in establishing a

satisfactory relationship. Any such termination will take place in accordance with written procedures established by Blue Shield and only after written notice to the Member which describes the unacceptable conduct, provides the Member with an opportunity to respond and warns the Member of the possibility of termination.

# How to Use Your Dental Plan

## Use of Dental Provider

At the time of enrollment, you will choose a Dental Provider that will provide and coordinate all covered dental services. You must contact your Dental Provider for all dental care needs including preventive services, routine dental problems, consultation with Plan Specialists, and Emergency Services. The Dental Provider is responsible for providing general Dental Care Services and coordinating or arranging for referral to other necessary Plan Specialists. The Plan must authorize such referrals.

To avoid a broken appointment charge, you must always cancel any scheduled appointments at least 24 hours in advance. Charges are listed in the section entitled "Summary of Benefits".

You should contact Dental Plan Member Services if you need assistance locating a dental Plan Provider in your Service Area. The Plan will review and consider your request for services that cannot be reasonably obtained in network. If your request for services from a non-Plan Provider is approved, the Plan will pay for Covered Services from the non-Plan Provider.

To obtain Benefits under your plan, you must attend the Dental Provider you selected or was designated for you. If for any reason you did not select a Dental Provider, contact your dental Member Services at: 1-888-256-3650.

## Referral to Plan Specialists

All specialty Dental Care Services must be provided by or arranged for by the Dental Provider. Referral by a Dental Provider does not guarantee coverage for the services for which the Member is being referred. The Benefit and eligibility provisions, exclusions, and limitations will apply. Members may be referred to a Plan Specialist within the Dental Center. However, you may also be referred to a Plan Specialist outside of the Dental Center if the type of specialty service needed is not available within your Dental Center.

If the Dental Provider determines specialty Dental Care Services are necessary, they will complete a referral form and you will then be able to schedule an appointment with the specialist. When no Plan Provider is available to perform the needed service, the Dental Provider will refer you to a non-Plan Provider after obtaining Authorization from a contracted Dental Plan Administrator. This Authorization procedure is handled for you by your Dental Provider.

Generally, your Dental Provider will refer you within the network of Blue Shield Plan Specialists in your area. After the specialty services have been rendered, the Plan Specialist will provide a complete report to your Dental Provider to ensure your dental record is complete.

## Emergency Services

For Emergency Services within your Service Area you should first notify your Dental Provider to obtain care, Authorization, or instructions for care prior to actual emergency treatment. If it is not possible to notify your Dental Provider prior to receiving Emergency Services, you must notify your Dental Provider within 24 hours after care is received unless it was not reasonably possible to communicate within this time limit. In such case, notice must be given as soon as possible. Failure to provide notice as stated may result in the services not being covered.

If you are in need of emergency treatment and are outside the geographic area of your designated Dental Provider, you should first contact a contracted Dental Plan Administrator to describe the emergency and receive referral instructions. If a contracted Dental Plan Administrator does not have a contracted Dentist in the area, or if you are unable to contact a contracted Dental Plan Administrator, you should contact a Dentist of your choice. You will be directly reimbursed for this treatment up to the maximum allowed under your Plan Benefits. Refer to the section titled "Responsibility for Co-payments, Charges for non-Covered Services and Emergency Claims" within the insert.

**NOTE: A contracted Dental Plan Administrator will respond to all requests for prior Authorization of services as follows:**

- for urgent services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
- for other services, within 5 business days from receipt of the request.

If you obtain services without prior Authorization from a contracted Dental Plan Administrator, a Dental Plan Administrator will retrospectively review the services for coverage as Emergency Services. If a contracted Dental Plan Administrator determines that the situation did not require Emergency Services, you will be responsible for the entire cost of the services. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

## Out-of-Area Benefits

If a Member receives Emergency Services outside the Service Area, the Member shall be entitled to reimbursement of up to $50 per occurrence for such Covered Dental Services. Whenever possible, the Member should ask the provider to bill the Plan directly.

Payment or reimbursement of Emergency Services provided to a Member will be made after a contracted Dental Plan Administrator receives documentation of the charges incurred and upon approval by a contracted Dental Plan Administrator of those charges set forth. Except for Emergency Services, as noted above, a Member will be responsible for full payment of dental services rendered outside the Service Area.

### In-Area Benefits (Those received within the Service Area)

Palliative Treatment received in an emergency from a non-Plan Provider will be covered according to the Summary of Benefits, if the Member has attempted but failed to reach his or her designated Dentist during the emergency.

If the Member receives Emergency Services from a non-Plan Provider, a contracted Dental Plan Administrator will retrospectively review the services provided. If a contracted Dental Plan Administrator determines that the situation did not require Emergency Services, the Member will be responsible for the entire cost of the services. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

### Limitation of Member Liability

When a Plan Provider renders Covered Services, the Member is responsible only for the applicable Copayments. Members are responsible for the full charges for any non-Covered Services they obtain.

If your provider ceases to be a Plan Provider, you will be notified in writing if you are affected. The provider is required to complete any work in progress, after which you must select a new provider. Once provisions have been made for the transfer of your care, services of a former Plan Dentist are no longer covered, except as provided for in the sections entitled “Choice of Dental Provider” and “Continuity of Care by a Terminated Provider”.

You will not be responsible for payment, other than Copayments, to a former Plan Provider for any Covered Services you receive prior to the effective date of the transfer to a new Dental Provider.

### Plan Benefits

The Benefits available to you under the Plan are listed in the Summary of Benefits. The Copayments for these services, if applicable, are also listed in the Summary of Benefits.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

### Important Information

The Dental Care Services described in this booklet are covered only if they are Medically Necessary and are provided, prescribed, or referred by your Dental Provider and are approved by a contracted Dental Plan Administrator. Coverage for these services is subject to all terms, conditions, limitations, and exclusions of this Agreement, and to the general exclusions and limitations set forth in the section entitled “General Exclusions and Limitations”. A contracted Dental Plan Administrator will not pay charges incurred for services without your Dental Provider’s and/or a contracted Dental Plan Administrator’s prior Authorization except for Emergency Services obtained in accordance with the section entitled “How to Use Your Dental Plan”.

The determination of whether services are Medically Necessary or are an emergency will be made by a contracted Dental Plan Administrator. This determination will be based upon the Plan's review consistent with generally accepted dental standards, and will be subject to appeal in accordance with the procedures outlined in the section entitled “Member Services and Grievance Process”.

### Member Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments by the Plan for Covered Services provided under the Plan.

## General Provisions

### Claims and Services Review

Blue Shield and a Dental Plan Administrator reserve the right to review all claims and services to determine if any exclusion or other limitations apply. Blue Shield or a Dental Plan Administrator may use the services of Dentist consultants, peer review committees of professional societies and other consultants to evaluate claims.

### Plan Provider Network

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

A Dental Plan Administrator has established a network of Dental Providers and other dental health professionals in your Service Area.

The Dental Provider(s) you and your Dependents select will provide telephone access 24 hours a day, 7 days a week so that you can obtain assistance and prior approval of necessary Dental Care Services. The Directory of Dental Providers in your Service Area indicates their location and phone numbers. The list is subject to change without notice.

Please contact your dental Member Services or your selected provider to verify his or her participation.

### Independent Contractors

Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall Blue Shield of California be liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any Dentist, physician, hospital, or other provider or their employees.

## Responsibility for Copayments, Charges for Non-Covered Services, and Emergency Claims

### Member Responsibility

The Member shall be responsible to the Dental Provider and other Plan Providers for payment of the following charges:

1. Any amounts listed under Copayments in the preceding Summary of Benefits.
2. Any charges for non-Covered Services.

All such Copayments and charges for non-Covered Services are due and payable to the Dental Provider or Plan Providers immediately upon commencement of extended treatments or upon the provision of services. Termination of the Plan shall in no way affect or limit any liability or obligation of the Member to the Dental Provider or other Plan Provider for any such Copayments or charges owing.

### Waiting Period

There is a 12-month waiting period for Orthodontic Services. A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services. If you had prior comprehensive coverage, the waiting period may be waived. For more information and to see if you qualify, please contact Member Services at 1-888-271-4880.

### Elective Treatment for Non-Covered Services

When the Member and Dentist opt to select a procedure that is more expensive than the covered Benefit, the Member will be responsible for the Copayment of the covered Benefit plus the difference between the Dentist's billed charges for the Covered Service and the selected procedure. If no dental service appearing on the Summary of Benefits is related to the procedure selected, the service is excluded as listed in the section entitled “General Exclusions”. In all instances, Benefits will be provided for Medically Necessary restoration of tooth structure.

### Emergency Claims

If Emergency Services outside of the Service Area were received and expenses were incurred by the Member, the Member must submit a complete claim with the Emergency Service record (a copy of the Dentist’s bill) for payment to a Plan Administrator, within 1 year after the treatment date.

Please send this information to:

Blue Shield of California

P.O. Box 30567

Salt Lake City, UT 84130-0567

If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not pre-authorized, a Dental Plan Administrator will review the claim retrospectively. If a Dental Plan Administrator determines that the services were not Emergency Services and would not otherwise have been authorized by a Dental Plan Administrator, and therefore, are not Covered Services under this Agreement, it will notify the Member of that determination. The Member is responsible for the payment of such Dental Care Services received. A Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim. If the Member disagrees with a Dental Plan Administrator’s decision, the Member may appeal using the procedures outlined in the section entitled “Member Services and Grievance Process”.

### Blue Shield Online

Blue Shield’s internet site is located at http://www.blueshieldca.com. Members using a personal computer and modem with World Wide Web access may view and download healthcare information and software.

## General Exclusions and Limitations

### General Exclusions

Unless otherwise specifically mentioned elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Dental services not appearing on the Summary of Benefits;
2. Services of Dentists or other practitioners of healing arts not associated with the Dental Service Plan, except upon referral arranged by a Dental Provider and authorized by the Plan or when required in a covered emergency;
3. Dental treatment that has been previously started by another Dentist prior to the participant's eligibility to receive Benefits under this Plan;
4. Dental services performed in a hospital or any related hospital fee;
5. Any procedure not performed in a dental office setting; except for general anesthesia when Medically Necessary;
6. Cosmetic procedures including, but not limited to, bleaching, veneer facings, porcelain on molar crowns,

personalization or characterization of crowns, bridges and/or dentures;

7. 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;
8. All prescription and non-prescription drugs;
9. Congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as Orthognathic surgery, including Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging;
10. 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;
11. Reimbursement to the Member or another dental office for the cost of services secured from Dentists, other than the Dental Provider or other Plan Provider, except:
    a. When such reimbursement is expressly authorized by the Plan; or
    b. As cited under the Emergency Services and Emergency Claims provisions;
12. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
13. Treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;
14. Treatment for which payment is made by any governmental agency, including any foreign government;
15. 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;
16. Bone grafting done for socket preservation after tooth extraction or in preparation for Implants;
17. Dental Implants (surgical insertion and/or removal), transplants, ridge augmentations, or socket preservation, and any appliance and/or crowns attached to Implants;
18. General anesthesia, including intravenous and inhalation sedation, except when of Medical Necessity.

    General anesthesia is considered Medically Necessary when its use is:

    a. In accordance with generally accepted professional standards;
    b. Not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; and
    c. Due to the existence of a specific medical condition.

    Written documentation of the medical condition necessitating use of general anesthesia or intravenous sedation must be provided by a physician (M.D.) to the Dental Provider and approved by a Dental Plan Administrator.

    Patient apprehension or patient anxiety will not constitute Medical Necessity.

    Mental disability is an acceptable medical condition to justify use of general anesthesia.

    The Plan reserves the right to review the use of general anesthesia to determine Medical Necessity.
19. Precious metals (if used, will be charged to the patient at the Dentist's cost);
20. Removal of 3rd molar (wisdom teeth) other than for Medical Necessity. Medical Necessity pertaining to the removal of 3rd molar (wisdom teeth) is defined as a pathological condition which includes horizontal, mesial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericoronitis alone is not Medically Necessary;
21. Services of prosthodontists;
22. Services of orthodontists;
23. Referral of a Dependent child age 6 and over to a pedodontist (specialist in children's dentistry), unless the child is mentally disabled and will not allow the general Dentist to treat after two attempts. All such exceptions must be approved by a Dental Plan Administrator;
24. Treatment as a result of Accidental Injury, including setting of fractures or dislocation;
25. Charges for second opinions, unless previously authorized by a Dental Plan Administrator;
26. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth re-

habilitation, splinting, fillings to restore tooth structure lost from attrition, erosion, or abrasion, appliances or any other method;

27. Services provided to Members by out-of-network Dentists unless preauthorized by the company, except when immediate dental treatment is required as a result of a dental emergency;
28. Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;
29. Replacement of lost, missing, stolen or damaged or prosthetic device;
30. Services arising from voluntary self-inflicted injury whether the patient is sane or insane;
31. House calls for dental services;
32. Training and/or appliances to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
33. 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;
34. Temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
35. Replacement of existing crown, bridges, or dentures that are less than five (5) years old;
36. Charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
37. Duplicate dentures, prosthetic devices or any other duplicate appliance;
38. Any and all Implant services that have not been prior authorized and approved by a Dental Plan Administrator. 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 Exclusions

1. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
2. Treatment in progress (after banding) at inception of eligibility;
3. Surgical Orthodontics incidental to Orthodontic treatment;
4. Treatment for myofunctional therapy;
5. Changes in treatment necessitated by an accident;
6. Treatment for TMJ (Temporomandibular Joint) disorder or dysfunction;
7. Ceramic braces which are considered to be Cosmetic;
8. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
9. Treatment exceeding twenty-four (24) continuous months;
10. In the event of a Member's loss of coverage for any reason, if at the time of loss of coverage the Member is still receiving Orthodontic treatment during the twenty-four (24) month treatment period, the Member and not a contracted Dental Plan Administrator will be responsible for the remainder of the cost for that treatment, at the participating Orthodontist's billed charges, prorated for the number of months remaining;
11. There is a twelve (12) month waiting period before beginning Orthodontic treatment;
12. If the Member elects to use the Invisalign® system or lingual, invisible, sapphire or clear braces, Member pays both the Member cost for standard Orthodontic system of brackets and wires, and the additional costs for the Invisalign® system or lingual, invisible, sapphire or clear braces beyond what Blue Shield and Member would pay for standard Orthodontic system of brackets and wires.

## Medical Necessity Exclusion

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

## 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 Dental Service Plan will pay Benefits based upon the less costly service.

## General Limitations

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

1. One (1) in six (6) months:
   a) Periodic oral exam;
   b) Routine prophylaxis;
   c) Fluoride treatment;
   d) Bitewing x-rays, maximum four (4) per year;

e) Tissue Conditioning;

f) Recementation 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 months;

g) Periodontal maintenance.

2. One (1) in twelve (12) months:

a) Dentures (complete or partial reline);

b) Oral cancer screening;

c) 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 (1) in twenty-four (24) months:

a) Full mouth debridement;

b) Gingival flap surgery per quad;

c) Diagnostic casts;

d) Sealants;

e) Occlusal guards.

4. One (1) in thirty-six (36) months:

a) Mucogingival surgery per area;

b) Osseous surgery per quad;

c) Gingival flap surgery per quad;

d) Gingivectomy per quad;

e) Gingivectomy per tooth;

f) Bone replacement grafts for periodontal purposes per site;

g) Guided tissue regeneration for periodontal purposes per site;

h) Full mouth series and panoramic x-rays;

i) Intraoral x-rays – complete series including bitewings.

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;

k) Diagnostic cast.

6. Referral to a specialty care Dentist is limited to Orthodontics, Oral Surgery, Periodontics, Endodontics and pediatrics.

7. In the case of a dental emergency involving pain or a condition requiring immediate treatment occurring more than fifty (50) miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an out-of-network Dentist up to the difference between the out-of-network Dentist's charge and the Member's Copayment up to a maximum of $50 for each emergency visit.

8. Oral Surgery services are limited to removal of teeth, bony protuberances and frenectomy.

9. 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 three (3) teeth missing in one quadrant or in the anterior region. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.

10. General or IV sedation is covered for:

a) Three (3) or more surgical extractions;

b) Any number of Medically Necessary impactions;

c) Full mouth or arch alveoloplasty;

d) Surgical root recovery from sinus;

e) Medical problem contraindicates local anesthesia.

General or IV sedation is not a covered Benefit for dentalphobic reasons.

11. Restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth.

12. Root canal treatment – one (1) per tooth per lifetime.

13. Root canal retreatment – one (1) per tooth per lifetime.

14. Pulpal therapy – through age five (5) on primary anterior teeth and through age eleven (11) on primary posterior teeth.

15. For mucogingival surgeries, one (1) site is equal to two (2) consecutive teeth or bounded spaces.

16. 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.
17. Scaling and root planing – covered once for each of the four quadrants of the mouth in a twenty-four (24) month period. Scaling and root planing is limited to two quadrants of the mouth per visit.
18. Coverage for referral to a pediatric specialty care Dentist is covered up to the age of six (6) and is contingent on Medical Necessity. However, exceptions for physical or mental handicaps or medically compromised children over the age of six (6), when confirmed by a physician, may be considered on an individual basis with prior approval.
19. Space maintainers – only eligible for Members through age eleven (11) when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.
20. Payment for Orthodontic treatment is made in installments. If for any reason Orthodontic services are terminated or coverage is terminated before completion of the approved Orthodontic treatment, the responsibility of the contracted Dental Plan Administrator will cease with payment through the month of termination.
21. Sealants – one (1) per tooth per two (2)-year period through age fifteen (15) on permanent first and second molars.
22. Child fluoride (including fluoride varnish) and child prophylaxis – one (1) per six (6) month period through age fifteen (15).

# Other Provisions

## Exception for Other Coverage

A Plan Dentist may seek reimbursement from other third party payers for the balance of its reasonable charges for services rendered under this Plan.

## Reductions - Third Party Liability

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

This right to restitution, reimbursement or other available remedy is against any recovery the Member 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 Member has been "made whole" by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The Member is required to:

1. Notify Blue Shield or a contracted Dental Plan Administrator in writing of any actual or potential claim or legal action which such Member 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 and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield 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 a lien calculated in accordance with the 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 and a contracted Dental Plan Administrator, in writing, within ten (10) days after any Recovery has been obtained.

A Member'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 Blue Shield or a contracted Dental Plan Administrator.

# Cancellation and Rescission Provisions

## Cancellation Without Cause

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

### Cancellation for Non-Payment of Dues – Notices

Blue Shield of California may cancel the Dental Service Plan for non-payment 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 of California will mail you a Notice of Cancellation for Nonpayment of Premiums and Grace Period.

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

Blue Shield of California 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, result in the cancellation or rescission of the Plan. Cancellations are effective on receipt or on such later date as specified in the cancellation notice. A rescission voids the contract retroactively as if it was never effective; Blue Shield will provide written notice prior to any rescission.

### Right of Cancellation

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

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

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

1. Providing material information that is false, or misrepresented information provided on the enrollment application or given to or Blue Shield of California; see the Cancellation/Rescission for Fraud, or Intentional Misrepresentations of Material Fact provision;
2. Permitting use of your Subscriber identification card by someone other than yourself or your Dependents to obtain services;
3. Obtaining or attempting to obtain services under the contract by means of false, materially misleading, or fraudulent information, acts or omissions;

If written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 31 days following that Dependent's effective date of coverage, Benefits under the Plan will be terminated on the 31st day at 11:59 P.M. Pacific Time.

## Limitations for Duplicate Coverage

### When you are eligible for Medi-Cal

Your Blue Shield of California plan always provides Benefits first.

### When you are a qualified veteran

If you are a qualified veteran your Blue Shield of California plan will pay the reasonable value or Blue Shield of California's or a contracted Dental Plan Administrator's Allowable Amount for Covered Services provided to you at a Veteran's Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield of California plan will pay the reasonable value or Blue Shield of California's, or a contracted Dental Plan Administrator's Allowable Amount for Covered Services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

### When you are covered by another governmental agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county, or other political subdivision, the combined benefits from that coverage and your Blue Shield of California Dental Plan will equal, but not exceed, what Blue Shield of California or a contracted Dental Plan Administrator would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield of California or a contracted Dental Plan Administrator's Allowable Amount).

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how Blue Shield of California coordinates your plan Benefits in the above situations.

### Entire Agreement: Changes

This Agreement, including the appendices, attachments, or other documents incorporated by reference, constitutes the entire Agreement. Any statement made by the Member shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Agreement shall be valid unless approved by a corporate officer of Blue Shield and unless a written endorsement is issued. No representative has authority to change this Agreement or to waive any of its provisions.

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

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

## Grace Period

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

## Time Limit on Certain Defenses

After a Member has been covered under this Agreement for two (2) consecutive years, Blue Shield of California will not use any omission, misrepresentation, or inaccuracy made by the applicant in an individual application to limit, cancel or rescind an Agreement, deny a claim, or raise Dues.

## 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 Agreement. No such action shall be brought after the expiration of 3 years after the time written proof of claim is required to be furnished.

## Endorsements and Appendices

Attached to and incorporated in this Agreement by reference is the Appendix pertaining to Dues and any endorsements (amendments to this Agreement) that, from time to time, may be issued. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

## Notices

Any notice required by this Agreement may be delivered by United States mail, postage prepaid. Notices to the Member may be mailed to the most current address appearing on the records of Blue Shield of California. Notice to Blue Shield may be mailed to:

Blue Shield of California

601 12th Street

Oakland, CA 94607

## Commencement or Termination of Coverage

Whether this Agreement may provide 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.

## Membership Identification Cards

Blue Shield will issue membership identification cards to all Subscribers.

## Statutory Requirements

This Agreement is subject to the Knox-Keene Act, Health Care Service Plan Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such Codes shall be binding upon Blue Shield whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations, which may include the Health Insurance Portability and Accountability Act. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield whether or not such provision is actually included in this Agreement.

## Legal Process

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

## Non-Assignability

Neither the coverage nor any Benefits of this Agreement may be assigned.

## Notice

The Subscriber hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Subscriber and Blue Shield of California (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 Agreement 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 Agreement. 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 Agreement.

# Member Services and Grievance Process

## Member Services

If you have a question about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may call your dental Member Services Department at:

1-888-256-3650

Member Services can answer many questions over the telephone.

You may write to:

Blue Shield of California
Dental Plan Administrator
425 Market St., 15th Floor
San Francisco, CA 94105

Note: A Dental Plan Administrator has established a procedure for our Members to request an expedited decision. A Member, physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. A Dental Plan Administrator shall make a decision and notify the Member and physician 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 Dental Member Services Department at the number listed above.

## Grievance Process

Members, a designated representative, or a provider on behalf of the Member, may contact the Dental Member Services Department by telephone, letter, or on-line to request a review of an initial determination concerning a claim or Service. Members may contact the Dental Member Services Department at the telephone number noted below. If the telephone inquiry to the Dental Member Services Department does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Dental Member Services Representative will initiate on the Member's behalf.

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

1-888-271-4880
Blue Shield of California
Dental Plan Administrator
425 Market Street, 15th Floor
San Francisco, CA 94105

A contracted Dental Plan Administrator will acknowledge receipt of a written grievance within 5 calendar days. Grievances are resolved within 30 calendar days.

The grievance system allows Members to file grievances within 180 days following any incident or action that is the subject of the enrollee's dissatisfaction. See the previous Member Services section for information on the expedited decision process.

## Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health Plan at 1-888-271-4880 and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in Nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's internet website **(http://www.dmhc.ca.gov)** has complaint forms, IMR application forms and instructions online.

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

## Confidentiality of Personal and Health Information

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Blue Shield will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Member Services at the number listed in the back of this booklet, or by accessing Blue Shield of California's Internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

**Correspondence Address:**

Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

**Free Telephone:**
1-888-266-8080

**Email Address:**
BlueShieldca_Privacy@blueshieldca.com

## Access to Information

Blue Shield of California 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 Agreement. You agree that any provider or entity can disclose to Blue Shield of California that information that is reasonably needed by Blue Shield of California. You agree to assist Blue Shield of California in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield of California with information in your possession. Failure to assist Blue Shield of California 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 of California will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

## Public Policy Participation Procedure

This procedure enables you to participate in establishing public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries, or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide Dental Care Services to them, their families, and the public (California Health and Safety Code, Section 1369).

At least one third of the Board of Directors of Blue Shield is comprised of Subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Phone Number: 1-510-607-2065

Please follow the following procedure:

1. Your recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of your letter;
2. Your name, address, phone number, Subscriber number and group number should be included with each communication;
3. The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter;
4. Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within 10 business days after the minutes have been approved.

# Definitions

Terms used throughout this Evidence of Coverage are defined as follows:

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

**Allowable Amount** – the amount a Plan Provider agrees to accept as payment from a contracted 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.

**Cosmetic** – any procedure, surgery, service, appliance, or supply that is not Medically 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** – 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 Plan Administrator (DPA)** – a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of dental services through a network of Plan Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Plan Dentists.

**Dental Provider (Plan Provider)** – 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 to the contract holder 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 a physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and
   c) thereafter, certification of continuing disability and

dependency from a physician must be submitted to Blue Shield 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 Member.

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

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

**Implants** – artificial materials including synthetic bone grafting materials which are implanted into, onto or under bone or soft tissue, or the removal of Implants (surgically or otherwise).

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

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

**Member** – either a Subscriber or Dependent.

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

**Open Enrollment Period –** that period of time set forth in the contract during which eligible 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 for the treatment for malocclusion and the proper alignment of teeth.

**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 Blue Shield DHMO Plan.

**Plan Dentist** – a Dental Center, Plan Specialist, or other Dental Provider who has an agreement with a contracted 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 contracted 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 Agreement, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this Agreement.

**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.

**IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Office, to take effect on the Subscriber's effective date.**

Steve Shearer
Vice President and General Manager
Individual and Family Plans
Blue Shield of California

## Dental Customer Service Telephone Numbers:

Blue Shield of California
Dental Plan Administrator
1-888-271-4880

Blue Shield of California
1-888-256-3650

## Dental Customer Service Correspondence Address:

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

## Claims for all Covered Services should be sent to:

Blue Shield of California
P. O. Box 30567
Salt Lake City, UT 84130-0567

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# Blue Shield of California

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

**Discrimination is against the law**

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

**Phone: (844) 831-4133 (TTY: 711)**
**Fax: (844) 696-6070**
**Email: BlueShieldCivilRightsCoordinator@blueshieldca.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

# Notice of the Availability of Language Assistance Services

## Blue Shield of California

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

**IMPORTANTE:** ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

**重要通知：**您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

**QUAN TRỌNG:** Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

**MAHALAGA:** Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

**Baa' ákohwiindzindooígí:** Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

**중요:** 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

**ԿԱՐԵՎՈՐ Է.** Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտիետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

**ВАЖНО:** Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

**重要：**お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

**مهم:** آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

**ਮਹੱਤਵਪੂਰਨ:** ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

**ប្រការសំខាន់៖** តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

**المهم :**هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

**TSEEM CEEB:** Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

**สำคัญ:** คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยเหลือจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

**महत्वपूर्ण:** क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

**ສິ່ງສຳຄັນ:** ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)