Dental HMO Plan

Evidence of Coverage and Health Service Agreement

Individual and Family Plans

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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, 50 BEALE STREET, SAN FRANCISCO, CALIFORNIA 94105. 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 1-888-702-4171 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 based on current dental terminology for 2009.

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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
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
D0270	Bitewing radiograph – single film	You pay nothing
D0272	Bitewing radiograph – two films	You pay nothing
D0274	Bitewing radiograph – four films	You pay nothing
D0330	Panoramic film (once every 36 months)	You pay nothing
D0460	Pulp vitality tests	You pay nothing
D0470	Diagnostic casts	You pay nothing
D9310	Specialist – consultation (as necessary)	$40

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ADA Code	Procedure	Member Copayment
	Preventive (cleanings and fluoride)	
D1110	Prophylaxis (adult) every 6 months	You pay nothing
D1120	Prophylaxis (child) every 6 months	You pay nothing
D1203	Topical application of fluoride - child	You pay nothing
D1206	Topical fluoride varnish	You pay nothing
D1330	Oral hygiene instruction	You pay nothing
D1351	Sealant per tooth	$11
D1510	Space maintainer - fixed - unilateral	$55
D1515	Space maintainer - fixed - bilateral	$55
D1520	Space maintainer - removable - unilateral	$55
D1525	Space maintainer - removable - bilateral	$55
D1550	Recementation of space maintainer	$17
	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	$90
D2390	Resin based composite crown, anterior	$90
	Major restorative (crowns)	
D2542	Onlay – metallic – two surfaces	$849
D2543	Onlay – metallic – three surfaces	$868
D2544	Onlay – metallic – four or more surfaces	$868
D2642	Onlay – porcelain / ceramic two surfaces	$851
D2643	Onlay – porcelain / ceramic three surfaces	$868
D2644	Onlay – porcelain / ceramic four or more surfaces	$868
D2662	Onlay – resin based composite two surfaces	$851
D2663	Onlay – resin based composite three surfaces	$868
D2664	Onlay – resin based composite four or more surfaces	$868
D2710	Crown – resin based composite (indirect)	$100

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ADA Code	Procedure	Member Copayment
D2712	Crown – ¾ 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 substrate[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
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	$50
D2980	Crown repair by report	$65
	Periodontics (gum disease)	
D4210	Gingivectomy/gingivoplasty four or more contiguous teeth or tooth bounded spaces - per quadrant	$138
D4211	Gingivectomy/gingivoplasty one to three contiguous teeth or tooth bounded spaces - per quadrant	$50

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Summary of Benefits

ADA Code	Procedure	Member Copayment
D4240	Gingival flap procedure including root planing four or more teeth - per quadrant	$165
D4241	Gingival flap procedure including root planing – one to three teeth - per quadrant	$83
D4260	Osseous surgery (including flap entry and closures) – four or more contiguous teeth or tooth bounded spaces - per quadrant	$303
D4261	Osseous surgery (including flap entry and closures) – one to three contiguous teeth or tooth bounded spaces - per quadrant	$152
D4263	Bone replacement graft - first site in quadrant	$154
D4264	Bone replacement graft – each additional site in quadrant	$154
D4266	Guided tissue regeneration - resorbable barrier – per site	$363
D4267	Guided tissue regeneration – non-resorbable barrier – per site (includes membrane removal)	$363
D4270	Pedicle soft tissue graft procedure	$435
D4271	Free soft tissue graft procedure (including donor site surgery)	$248
D4273	Subepithelial connective tissue graft procedure - per tooth	$363
D4276	Combination connective tissue and double pedicle graft -per tooth	$435
D4341	Periodontal scaling and root planing – four or more teeth / per quadrant	$75
D4342	Periodontal scaling and root planing – one to three teeth / per quadrant	$38
D4355	Full mouth debridement before comprehensive treatment	$75
D4910	Periodontal maintenance	$55
D9951	Occlusal - limited	$60
D9952	Occlusal adjustment - complete	$100
	Prosthetics removable (dentures)	
D5110	Complete denture- maxillary	$400
D5120	Complete denture – mandibular	$400
D5130	Immediate denture - maxillary	$400
D5140	Immediate denture – mandibular	$400
D5211	Maxillary partial- resin base (including any conventional clasps, rests and teeth)	$325
D5212	Mandibular partial - resin base (including any conventional clasps, rests, and teeth)	$325
D5213	Maxillary partial - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$375
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$375
D5225	Maxillary partial denture - flexible base (including any clasps, rests, and teeth)	$375
D5226	Mandibular partial denture - flexible base (including any clasps, rests, and teeth)	$375
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$475

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Summary of Benefits

ADA Code	Procedure	Member Copayment
D5410	Adjust complete or partial denture - maxillary	$85
D5411	Adjust complete denture - mandibular	$85
D5421	Adjust partial denture - maxillary	$85
D5422	Adjust partial denture - mandibular	$85
D5510	Denture repair – complete denture, broken base	$30
D5520	Denture repair – missing or broken teeth – complete denture – each tooth	$30
D5610	Denture repair – acrylic saddle or base	$30
D5620	Denture repair – cast framework	$35
D5630	Denture repair – repair or replace clasp	$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
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	$60
D5851	Tissue conditioning – mandibular	$65
	Bridge abutments or pontics	
D6205	Pontic – indirect resin based composite	$100
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

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Summary of Benefits

ADA Code	Procedure	Member Copayment
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
D6545	Retainer- cast metal for resin bonded fixed prosthesis[1]	$205
D6548	Retainer – porcelain / ceramic for resin bonded fixed prosthesis	$205
D6608	Onlay – porcelain / ceramic two surfaces[1]	$851
D6609	Onlay – porcelain / ceramic three surfaces[1]	$868
D6610	Onlay – cast high noble metal – two surfaces[1]	$851
D6611	Onlay – cast high noble metal – three or more surfaces[1]	$868
D6612	Onlay – cast predominantly base metal – two surfaces[1]	$851
D6613	Onlay – cast predominantly base metal – three or more surfaces[1]	$868
D6614	Onlay – cast noble metal – two surfaces[1]	$851
D6615	Onlay – cast noble metal – three or more surfaces[1]	$868
D6634	Onlay - titanium	$129
D6710	Bridge retainer – crown – indirect resin based composite	$100
D6720	Bridge retainer – crown – resin with high noble metal[1]	$100
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
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
D6794	Bridge retainer – crown – titanium[1]	$300
D6930	Recement fixed partial denture	You pay nothing
D6970	Cast post and core in addition to fixed bridge retainer	$62
D6972	Prefabricated post with core buildup in addition to fixed partial denture retainer, indi-	$100

ADA Code	Procedure	Member Copayment
	rectly fabricated	
D6976	Each additional indirectly fabricated post – same tooth	$170
D6977	Each additional prefabricated post – same tooth	$50
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	Pulpotomy	$36
D3310	Root canal therapy – anterior tooth (excluding final restoration)	$155
D3320	Root canal therapy – bicuspid tooth (excluding final restoration	$235
D3330	Root canal therapy – molar tooth (excluding final restoration)	$290
D3410	Apicoectomy / periradicular surgery – anterior	$265
D3421	Apicoectomy / periradicular surgery – bicuspid (first root)	$240
D3425	Apicoectomy / periradicular surgery – molar (first root)	$250
D3426	Apicoectomy / periradicular surgery – molar (each additional root)	$126
D3430	Retrograde filling – per root	$120
D3450	Root amputation – per root	$276
D3920	Hemisection (including any root removal; not including root canal therapy)	$264
	Oral surgery	
D7111	Extraction of coronal remnants deciduous tooth	$15
D7140	Extraction of erupted tooth or exposed root	$34
D7210	Surgical removal of erupted tooth	$70
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	$363
D7286	Biopsy of oral tissue – soft [3]	$176
D7287	Exfoliative cytological sample collection	$88
D7288	Brush biopsy - transepiteliel sample collection	$88
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	$35

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Summary of Benefits

ADA Code	Procedure	Member Copayment
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	$182
D7960	Frenectomy/Frenotomy – separate procedure	$120
D7963	Frenuloplasty	$120
D7970	Excision of hyperplastic tissue - per arch[3]	$176
D7971	Excision of pericoronal gingival[3]	$105
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain – minor procedure [4]	$28
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	$190
D9221	General anesthesia - each additional 15 minutes	$110
D9241	IV sedation – first 30 minutes	$200
D9242	IV sedation - each additional 15 minutes	$110
D9440	Office visit – after regularly scheduled hours	$40
D9450	Case presentation	You pay nothing
D9910	Application of desensitizing medicament	$22
	Other	
	Failed Appointment (without 24-hour notice)	$15
	Sterilization surcharge	$5
	Orthodontics[5,6,7] Orthodontic treatment to correct malocclusion, limited to one continuous two-year course of treatment. There is a 12-month waiting period for these procedures.	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2, 350
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,650
D9940	Occlusal guards by report	$170

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Summary of Benefits

ADA Code	Procedure	Member Copayment
D9942	Repair and /or reline of occlusal guard	$51

Footnotes:

[1] Precious and semi-precious metals, if used, will be charged to the patient at the additional cost of the metal. Porcelain on molar teeth 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] 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 contracted Dental Plan Administrator (DPA), which is an entity that contracts with Blue Shield to administer the delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

If you have any questions regarding the information in this booklet, need assistance, or have any problems, you may contact your dental Member Services Department at: 1-888-679-8928.

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 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 Customer 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 19 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 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 19 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.

4. If a Member commits any of the following acts, they will immediately lose eligibility to continue enrollment
   a. Abusive or disruptive behavior which:

      (1) Threatens the life or well being of Blue Shield of California personnel and providers of Services; or

      (2) Substantially impairs the ability of Blue Shield of California to arrange for Services to the Person; or

      (3) Substantially impairs the ability of providers of Service to furnish Services to the Person or to other patients;

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

5. A Member will also lose eligibility under the Plan, upon 30 days written notice, if they are unable to establish a satisfactory physician-patient relationship after following the procedures in the Relationship with your Dental Provider section;

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 / Reinstatement of the Agreement

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 thirty (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:

   a. 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.

6. Reinstatement of the Agreement after Termination for Non-Payment:

   If the Agreement is cancelled for nonpayment of Dues, Blue Shield of California will permit reinstatement of the Agreement or coverage twice during any twelve-month period, without a change in Dues and without consideration of the medical condition of you or any Dependent, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

   If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Agreement is cancelled for nonpayment of Dues more than twice during the preceding twelve-month period, then Blue Shield of California is not required to reinstate you, and you will need to re-apply for coverage. In this case, Blue Shield of California may impose different Dues and consider the medical condition of you and your Dependents.

Renewal of the Agreement:

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

1. Non-payment 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 1-800-431-2809 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:

Blue Shield of California

P.O. Box 51827

Los Angeles, CA 90051-6127

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 1-888-679-8928. 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.

Payment of Providers

Blue Shield contracts with a contracted 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 Member Services at 1-888-679-8928 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 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 Dentally 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 your no longer meeting the eligibility and enrollment requirements for the Plan. However such an event will only occur after you have been given access to other available Dental Providers and have been unsuccessful in establishing a satisfactory relationship. Any such change in your Eligibility 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 no longer remaining eligible to be covered under the Plan.

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.

To obtain Benefits under your plan, you must attend the dental Provider you selected. If for any reason you did not select a Dental Provider, contact your dental Member Services at: 1-888-679-8928

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

Emergency Services include covered services to alleviate severe pain or other symptoms or for the diagnosis and treatment of an unforeseen illness or injury that a reasonable person under the circumstances would believe if not treated immediately could lead to serious jeopardy of health or impairment. The determination of whether the situation required Emergency Services will be made retrospectively by the Dental Director based upon an objective review that is consistent with professionally recognized standards of care.

Note: A contracted Dental Plan Administrator will respond to all requests for prior authorization of services as follows:

1. For urgent services, within 72 hours from receipt of the request;
2. For other services, within 5 business days from receipt of the request.

Out-of-Area Benefits

If a Member receives Emergency care outside the service area, the Member shall be entitled to reimbursement of up to fifty dollars ($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 care 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 care, 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-Participating Provider will be covered according to the Summary of Benefits, if the Member has attempted but failed to reach his or her Primary Dentist during the Emergency.

If the Member receives Emergency care from a non-Participating 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 care, 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 Dental 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 (Benefits) described in this booklet are covered only if they are of Dental Necessity 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 of Dental Necessity 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 contracted 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 contracted 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 HEALTH CARE MAY BE OBTAINED.

A contracted 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, seven 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 omis-

sions 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.

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 Dentally 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 contracted Dental Plan Administrator, within one (1) year after the treatment date.

Please send this information to:

Blue Shield of California

P. O. Box 272590

Chico, CA 95927-2590

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 contracted Dental Plan Administrator will review the claim retrospectively. If a contracted Dental Plan Administrator determines that the services were not Emergency Services and would no otherwise have been authorized by a contracted 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 contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim. If the Member disagrees with a contracted Dental Plan Administrator's decision, the Member may appeal using the procedures outlined in the section entitled Member Services and Grievance Process.

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 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. Procedures that are principally cosmetic in nature, including, but not limited to, bleaching, veneer facings, crowns, porcelain on molar crowns, personalization or characterization of crowns, bridges and/or dentures;
5. Dental services performed in a hospital or any related hospital fee;
6. Any procedure not performed in a dental office setting;
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 contracted 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 Authorized Provider, except:

    a. When such reimbursement is expressly authorized by the Plan; or

    b. As cited under the Emergency Services 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 which payment is made by any governmental agency, including any foreign government;

14. Diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint;

15. Dental implants (surgical insertion and/or removal), transplants, ridge augmentations, or socket preservation, and any appliance and/or crowns attached to implants;

16. General anesthesia, including intravenous and inhalation sedation, except when of Dental Necessity.

    General anesthesia is considered Dentally Necessary when its use is:

    a. In accordance with 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 contracted Dental Plan Administrator.

    Patient apprehension or patient anxiety will not constitute Dental Necessity.

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

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

17. Precious metals (if used, will be charged to the patient at the Dentist's cost);

18. Removal of 3rd molar (wisdom teeth) other than for Dental Necessity. Dental 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 dental necessity;

19. Services of Prosthodontists;

20. Treatment as a result of accidental injury, including setting of fractures or dislocation;

21. Charges for second opinions, unless previously authorized by a contracted Dental Plan Administrator;

22. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion, or abrasion, appliances or any other method;

23. 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.

24. 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;

25. Services arising from voluntary self-inflicted injury;

26. House calls for dental services;

27. Training and/or appliances to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
28. 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;
29. Temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
30. Replacement of existing crown, bridges, or dentures that are less than five (5) years old;
31. Duplicate dentures, prosthetic devices or any other duplicate appliance;

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

Dental Necessity Exclusion

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

Alternate Benefits Provision

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the Dental 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 a six (6) month period:
   a) Periodic oral exam;
   b) Routine prophylaxis;
   c) Fluoride treatment;
   d) Bitewing x-rays, maximum four (4) per occurrence;
   e) Tissue Conditioning;
   f) Recementation if the crown was provided by other than the original dentists; not eligible if the dentist doing the recementation of a service he/she provided within twelve months
2. One (1) in twelve months:
   a) Dentures (complete or partial reline;
   b) Oral cancer screening
3. One (1) in twenty-four (24) months:
   a) Full mouth debridement;
   b) Sealants;
   c) Occlusal guards;

4. One in thirty-six 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;
    g) Guided tissue regeneration for periodontal purposes;
    h) Full mouth series and panoramic x-rays
5. One (1) in a five (5) year period:
    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 casts
6. Referral to a specialty care dentist is limited to orthodontics, oral surgery, periodontics, endodontics and pediatrics.
7. Coverage for referral to a pediatric specialty care dentist is covered up to the age of six (6) and is contingent on dental 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.
8. Space maintainers – only eligible for Members through age eleven 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.
9. 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.
10. Sealants – one per tooth per two-year period through age fifteen on permanent first and second molars.
11. Child fluoride (including fluoride varnish) and child prophylaxis – one per six (6) month period through age fifteen.
12. 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.
13. Oral surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy and crown lengthening.
14. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the 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.
15. General or IV Sedation is covered for:
    a) 3 or more surgical extractions;
    b) Any number of dentally necessary impactions;
    c) Full mouth or arch alveoloplasty;
    d) Surgical root recovery from sinus;

e) Medical problem contraindicates local anesthesia.

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

16. Restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth.
17. Root canal treatment – one per tooth per lifetime.
18. Root canal retreatment – one per tooth per lifetime.
19. Pulpal therapy – through age five on primary anterior teeth and through age eleven on primary posterior teeth.
20. For mucogingingival surgeries, one (1) site is equal to two (2) consecutive teeth or bounded spaces.
21. Scaling and root planing – covered once for each of the four quadrants of the mouth in a 24 month period. Scaling and root planing is limited to two quadrants of the mouth per visit.

Other Provisions

Exception for Other Coverage

A Plan Provider 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.

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, den 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 three (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 are 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, 50 Beale Street, San Francisco, CA 94105.

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:

1-888-679-8928

Member Services can answer many questions over the telephone.

You may write to:

Blue Shield of California
Dental Plan Administrator
425 Market St., 12th Floor
San Francisco, CA 94105

Note: Dental Benefit Providers 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. Dental Benefit Providers 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 as 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.

1-888-679-8928
Blue Shield of California
Dental Plan Administrator
425 Market Street, 12th. Floor
San Francisco, CA 94105

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

The grievance system allows Members to file grievances for at least 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 1-800-424-6521 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-HMO-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

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

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 Participating Procedure

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

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

At least one third of the Board of Directors of Blue Shield 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
50 Beale Street
San Francisco, CA 94105
Phone Number: 415-229-5065

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

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

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

Allowed Amount - the amount a Plan Provider agrees to accept as payment from a contracted Dental Plan Administrator or the billed amount for non-Plan providers.

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, child, brother, sister or parent of a Subscriber or Dependent.

Copayment – the amount that a Member is required to pay for certain Services after meeting any applicable deductible.

Cosmetic Procedure - any surgery, service, appliance, or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasing or unsightly.

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

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

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

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

Dental Plan Administrator (DPA) – Blue Shield has contracted with a Dental Plan Administrator (DPA). A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

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

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

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

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

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

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

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

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 Subscriber's, spouse's, or Domestic Partner's child (including any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction who is not covered for Benefits as a Subscriber; who is:

    a. A Resident of California; and

    b. Less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardian); and who has been enrolled and accepted by Blue Shield of California as a Dependent and has maintained membership in accordance with this Agreement.

Note: Children of Dependent children (i.e. grandchildren of the Subscriber, spouse, or Domestic Partner) are not Dependents unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4. If coverage for a Dependent child would be terminated because of the attainment of age 26 and the Dependent child is disabled, benefits for such Dependent will be continued upon the following conditions:

    a. The child my be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance and be incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition;

    b. The Subscriber, spouse, or Domestic Partner submits to Blue Shield of California a Physician's written certification of disability within 60 days from the date of Blue Shield of California's request; and

    c. Thereafter, Certification from a Physician is submitted to Blue Shield of California on the following schedule:

        i. Within 24 months after the month when the Dependent would otherwise have been terminated; and

        ii. Annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this plan for any reason other than attained age.

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

1. Both partners are:

    a. 18 years of age or older; and

    b. of the same or different sex; and

    c. Residents of California.

2. The partners share:

    a. An intimate and committed relationship of mutual caring; and

    b. The same principal residence.

3. The partners are:

    a. Not currently married; and

    b. Not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited.

4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

Dues - the pre-payment that is made to the Plan on behalf of each Member.

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

1. **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: placing the patient's health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part.

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.

Member - either a Subscriber or Dependent.

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 - 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 Provider - 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.

Notice of the Availability of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Julie Roberts
Vice President, Office of Health Reform and
General Manager, Individual and Family Plans
Blue Shield of California

Dental Customer Service Telephone Numbers:

Blue Shield of California
Dental Plan Administrator
1-888-679-8928

Blue Shield of California
1-800-431-2809

Dental Customer Service Correspondence Address:
Blue Shield of California
Dental Plan Administrator
Dental Customer Service
425 Market Street, 12th Floor
San Francisco, CA 94105

Claims for all Covered Services should be sent to:
Blue Shield of California
P. O. Box 2722590
Chico, CA 5927-2590

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