Enhanced Dental PPO 25/500

Evidence of Coverage and Health Service Agreement

Individual and Family Plan

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Blue Shield of California
Individual and Family
Evidence of Coverage

NOTICE

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

Please read this Evidence of Coverage carefully and completely so that you understand which services are covered and the terms and conditions that apply to your Plan. If you have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

At the time of your enrollment, Blue Shield of California provides you with a Matrix summarizing key elements of your Blue Shield of California Dental Plan you are being offered. This is to assist you in comparing other dental plans available to you.

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Member Services at the address or telephone number listed in the Member Services paragraphs of the Other Provisions section of this booklet.

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 contract.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the contract. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.

IMPORTANT

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

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Enhanced Dental PPO 25/500

Summary of Benefits

Dental PPO Plan

Member Calendar Year Deductible (Dental Plan Deductible)	Deductible Responsibility	
	Plan Dentists	**Non-Plan Dentists**
Deductible per Member and maximum Deductible per Family	$25 per Member / $75 per Family	$25 per Member / $75 per Family
Deductible applies to	basic & major services only	All services

Maximum Calendar Year Payment	Maximum Blue Shield Payment	
	Plan Dentists	**Non-Plan Dentists**
For all Covered Services The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.	$500 per Member	

Covered Services and Supplies[1]	Blue Shield Payment Percentage	
	Plan Dentists	**Non-Plan Dentists[2]**
Diagnostic and Preventive Services – cleanings, exams, x-rays, caries risk management (CAMBRIA)[3]	100%	80%
Basic Services – minor restorations and oral surgery	80%	60%
Major Services – bridges, crowns, dentures, endodontics, periodontics	50%	50%

Footnotes

[1] Waiting Periods
No waiting periods for cleanings, exams and x-rays
6-month waiting period for basic services
12-month waiting period for major services

[2] For Covered Services rendered by Non-Plan Dentists, the Member is responsible for all charges above the Allowable Amount.

[3] Caries risk management - CAMBRA (Caries Management By Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; "medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to 2 fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

Introduction to the Enhanced Dental PPO 25/500

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

Your interest in Blue Shield of California Enhanced Dental PPO 25/500 is truly appreciated. Blue Shield of California (Blue Shield) has been serving Californians for over 60 years, and we look forward to serving your dental care needs.

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

Before Obtaining Dental Services

You are responsible for assuring that the Dentist you choose is a Plan Dentist. Note: A Plan Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Plan Dentist in case there have been any changes to the list of Plan Dentists. A list of Plan Dentists located in your area, can be obtained by contacting a Dental Plan Administrator at 1-888-679-8928. You may also access a list of Plan Dentists through Blue Shield of California's internet site located at http://www.blueshieldca.com. You are also responsible for following the Precertification of Dental Benefits Program which includes obtaining or assuring that the Dentist obtains precertification of Benefits.

NOTE: A Dental Plan Administrator will respond to all requests for precertification and prior Authorization within 5 business days from receipt of the request. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a Dental Plan Administrator will respond within 72 hours from receipt of the request.

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

Plan Dentists

The Blue Shield of California Enhanced Dental PPO 25/500 is specifically designed for you to use Plan Dentists. Plan Dentists agree to accept a Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Copayment or Coinsurance, as payment in full for Covered Services. This is not true of Non-Plan Dentists.

If you go to a Non-Plan Dentist, you will be reimbursed up to a pre-determined maximum amount, for Covered Services. Your reimbursement may be substantially less than the billed amount. The Subscriber is responsible for all differences between the amount you are reimbursed and the amount billed by Non-Plan Dentists. It is therefore to your advantage to obtain dental services from Plan Dentists.

Plan Dentists submit claims for payment after their services have been rendered. These payments go directly to the Plan Provider. You or your Non-Plan Providers submit claims for reimbursement after services have been rendered. If you receive services from Non-Plan Providers, you have the option of having payments sent directly to the Non-Plan Provider or sent directly to you. A Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

Providers do not receive financial incentives or bonuses from Blue Shield of California.

The Member should contact Customer Services if the Member needs assistance locating a provider in the Member's Service Area. The plan will review and consider a Member's request for services that cannot be reasonably obtained in network. If a Member's request for services from a Non-Plan Provider is approved at an in-network benefit level, the Plan will pay for Covered Services at a Plan Dentist level.

You may also access a list of Plan Dentists through Blue Shield's Internet site located at http://www.blueshieldca.com.

Continuity of Care by a Terminated Provider

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

Financial Responsibility for Continuity of Care Services

If a Member is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for services rendered under the Continuity of Care provision shall be no greater than for the same services rendered by a Plan Dentist in the same geographic area.

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. Applications can only be approved by Blue Shield of California's Underwriting Department.
3. An applicant, upon completion and approval by Blue Shield of California of the application, is entitled to the Benefits of

this Health Services Agreement (Agreement) upon the effective date.

4. The effective date of the Benefits of a newborn child will be the date of birth if the Subscriber 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 Subscriber wishes to add a newborn child as a Dependent 32 or more days after birth, coverage will not be retroactive and there will be a gap in coverage. See Paragraph 6 below.

5. The effective date of Benefits for an adopted child will be the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, if the Subscriber requests the child be added to this Agreement as a Dependent. Such request must be 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 Subscriber 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, spouse, 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 Subscriber wishes to add a child placed for adoption as a Dependent 32 or more days after the date the Subscriber, 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 of 26 as long as they apply during a period no longer than 63 days after any event listed below:

   a. Losing Dependent coverage due to:

      (i) The termination or change in employment status of this Dependent or the person through whom this Dependent was covered; or

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

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

      (iv) Legal separation or divorce; or

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

   c. Adoption of the child; or

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

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

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

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

Limitation of Enrollment

1. Subscribers must be Residents of California. Upon change of residence outside of California, the Blue Shield of California Individual and Family Dental PPO Plan will terminate.

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

   a. The date the Dependent child attains age 26; or

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

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

Duration of the Agreement

This Agreement shall be renewed upon receipt of pre-paid Dues. Renewal is subject to Blue Shield of California's right to amend this Agreement. Any change in Dues or Benefits, including but not limited to Covered Services, Deductible, Copayment, and

annual Copayment maximum amounts, 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; or

   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.

   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:

   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 or not renewing 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.

Precertification of Dental Benefits

Before any course of treatment expected to cost more than $250 is started, you should obtain precertification of Benefits. Your Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic x-rays to a Dental Plan Administrator. A Dental Plan Administrator will review the dental treatment plan to determine the Benefits payable under the plan. The benefit determination for the proposed treatment plan will then be promptly returned to the Dentist. When the treatment is completed, your claim form should be submitted to a Dental Plan Administrator for payment determination. A Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

The dental plan provides Benefits for Covered Services at the most cost-effective level of care that is consistent with professionally recognized standards of care. If there are two or more professionally recognized procedures for treatment of a dental condition, this plan will in most cases provide Benefits based on the most cost-effective procedure. The Benefits provided under this plan are based on these considerations but you and your Dentist make the final decision regarding treatment.

Failure to obtain precertification of Benefits may result in a denial of Benefits. If the precertification process is not followed, a Dental Plan Administrator will still determine payment by taking into account alternative procedures; services or materials for

the dental condition based on professionally recognized standards of dental practice. However, by following the precertification process both you and your Dentist will know in advance which services are covered and the Benefits that are payable.

The covered dental expense will be limited to the Allowable Amount for the procedure, service or material which meets professionally recognized standards of quality dental care and is the most cost effective as determined by a Dental Plan Administrator. If you and your Dentist decide on a more costly procedure, service or material than a Dental Plan Administrator determined is payable under the plan, then Benefits will be applied to the selected treatment plan up to the benefit maximum for the most cost effective alternative. You will be responsible for any charges in excess of the benefit amount. A Dental Plan Administrator reserves the right to use the services of dental consultants in the precertification review.

Example:

1. If a crown is placed on a tooth which can be restored by a filling, Benefits will be based on the filling;
2. If a semi-precision or precision partial denture is inserted, Benefits may be based on a conventional clasp partial denture;
3. If a bridge is placed and the patient has multiple unrestored missing teeth, Benefits will be based on a partial denture.

Payment and Subscriber Copayment Responsibilities

Plan Dentists

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

When you receive covered dental services from a Plan Dentist, you will be responsible for a fixed Copayment as outlined in the section entitled Summary of Benefits and Member Copayments. Plan Dentists will file claims on your behalf.

Services rendered for diagnostic and preventive care will be paid at 100%, subject to certain limitations as specified in the section entitled “Covered Services and Supplies”.

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

If the covered Member recovers from a third party the reasonable value of Covered Services rendered by a Plan Dentist, the Plan Dentist who rendered these services is not required to accept the fees paid by a contracted Dental Plan Administrator as payment in full, but may collect from the covered Member the difference, if any, between the fees paid by a Dental Plan Administrator and the amount collected by the covered Member for these services.

Non-Plan Dentists

When you receive Covered Services from a Non-Plan Dentist, you will be reimbursed up to a specified maximum amount as outlined in the section entitled “Summary of Benefits and Member Copayments”. You will be responsible for the remainder of the Dentist’s billed charges. You should discuss this beforehand with your Dentist if he is not a Plan Dentist. Any difference between a Dental Plan Administrator’s or Blue Shield of California’s payment and the Non-Plan Dentist's charges are your responsibility. Members are expected to follow the billing procedures of the dental office.

If you receive Covered Services from a Non-Plan Dentist, either you or your provider may file a claim using the dental claim form which may be obtained by calling Dental Member Services at:

1-888-271-4880

Only claims for Benefits for Enhanced Dental services for pregnant women rendered by Non-Plan Dentists should be sent to:

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

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

Blue Shield of California
Dental Plan Administrator
P O Box 272590
Chico, CA 95927-2590

Calendar Year Deductible

For Plans with a Calendar Year Deductible, the Deductible applies to all covered Services and supplies furnished by Participating and Non-Participating Dentists, except as specified in the Summary of Benefits which is attached to and made a part of this EOC. It is the amount which you must pay out of pocket for charges that would otherwise be payable for dental care Services and supplies. Charges in excess of the Allowable Amount do not apply toward the Deductible. This per Member Deductible applies separately to each covered Member each Calendar Year, except that no more than the Family Deductible amount is required of a Family in a Calendar Year. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan.

Reimbursement Provisions

Procedure for Filing a Claim

Claims for covered dental services should be submitted on a dental claim form which may be obtained from the contracted Dental Plan Administrator or at blueshieldca.com. Have your Dentist complete the form and mail it to the contracted Dental Plan Administrator service center shown on the last page of this booklet.

A contracted Dental Plan Administrator will provide payment in accordance with the provisions of this Agreement. You will re-

ceive an explanation of Benefits after the claim has been processed.

All claims for reimbursement must be submitted to a contracted Dental Plan Administrator within one (1) year after the month in which the service is rendered. A contracted Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

Calendar Year Maximum Payment

The calendar year maximum for covered Services and Supplies provided by Participating Dentists and Non-Participating Dentists is specified on the Summary of Benefits.

Principal Benefits & Coverages

The Benefits of the Plan are listed in the Summary of Benefits which is inserted as part of this booklet. Blue Shield payments for these services, if applicable, are also listed in the Summary of Benefits.

IMPORTANT INFORMATION

Services are Benefits of the Plan when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the contract, to any conditions or limitations set forth in the benefit descriptions below, and to the limitations and exclusions listed in this booklet.

Benefits of the plan are provided for services customarily performed by Dentists for treatment of teeth, jaws and their dependent tissues.

These Benefits are subject to the general limitations and exclusions of the plan. Payments are subject to the dental Benefit Deductible and to the Copayment amounts indicated in the section entitled "Summary of Benefits and Member Copayments".

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

Diagnostic and Preventive Services

Diagnostic and preventive services provided by Plan Dentists will be covered at 100%, subject to the limitations in the General Limitations section and are not subject to the $50 Calendar Year Deductible.

Enhanced Dental Benefits for Pregnant Women

This Plan provides additional or enhanced Benefits for certain services for women who are pregnant. When the Benefits below are available, they are not subject to the Calendar Year Deductible.

1. One (1) additional routine adult prophylaxis including periodontal prophylaxis for gingivitis for women during pregnancy. Note: This prophylaxis is in addition to the prophylaxis provided under the section entitled "Diagnostic and Preventive Services"; and
2. One (1) periodontal maintenance visit if warranted by a history of periodontal treatment; and
3. One (1) course of up to four (4) quadrants of periodontal scaling and root planing for women during pregnancy with a documented existing periodontal condition [1].

[1] If these services are required outside of pregnancy, coverage is available under the section entitled "Endodontics, Oral Surgery, Periodontics and Restorative Services".

Basic Services

Anesthesia, Consultations, Oral Surgery, and Restorative Services

Refer to the section entitled "Summary of Benefits and Member Copayments" for fixed Copayments and maximum reimbursement amounts.

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

Consultations

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

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

Major Services

Bridges, Crowns, Dentures, Endodontics, and Periodontics

Refer to the section entitled Summary of Benefits and Member Copayments for fixed Copayments and maximum reimbursement amounts.

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

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

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

No replacement of dentures (complete or partial), crowns or fixed bridgework due to provider error. The provider is financially responsible for comparable replacement. If replacement is warranted because of an action by, or the non-compliance of, the patient, that patient is financially liable for replacement of the Prosthesis (this includes decay or periodontal disease directly related to patient non-compliance). The Plan will pay for a replacement in this instance after the sixty (60) months waiting period from initial placement has elapsed.

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

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

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

Important Information

Services are Benefits of the Plan when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Plan, to any conditions or limitations set forth in the benefit descriptions below, and to the limitations and exclusions listed in this booklet.

Benefits of the Plan are provided for services customarily performed by licensed Dentists for treatment of teeth, jaws and their dependent tissues.

Payments are based on the Allowable Amount as defined, and are subject to the dental Benefit Deductible, the indicated Coinsurance percentages, and all Benefit maximums as specified in the Summary of Benefits.

General Exclusions and Limitations

General Exclusions

Unless exceptions to the following general exclusions are specifically made elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Dental services not appearing on the Summary of Benefits;
2. Charges for services in connection with any treatment to the gums for tumors, cysts and neoplasms;
3. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers compensation law, occupational disease law or similar legislation. However, if a contracted Dental Plan Administrator or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by a contracted Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;
4. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint;
5. Congenital mouth malformations or skeletal imbalances, including treatment required as the result of Orthognathic surgery, Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
6. All prescription and non-prescription drugs;
7. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;

8. Services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;
9. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;
10. Cosmetic procedures including, but not limited to, bleaching, veneer facings, porcelain on molar crowns, personalization or characterization of crowns, bridges and/or dentures;
11. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been either lost or stolen within five (5) years of its installation;
12. Myofunctional therapy; biofeedback procedures; athletic mouth-guards; precision or semi-precision attachments; denture duplication; treatment of jaw fractures;
13. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw; charges for services in connection with orthodontia;
14. Charges for services in connection with orthodontia;
15. Alloplastic bone grafting materials;
16. Bone grafting done for socket preservation after tooth extraction (unless your Plan provides special Implant Benefits. Please see the Summary of Benefits to determine if you have Implant Benefits.);
17. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
18. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
19. Any procedure not performed in a dental office setting; except for general anesthesia when Dentally Necessary;
20. Dental services performed in a hospital or any related hospital fee;
21. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;
22. Services for which the Member is not legally obligated to pay, or for services for which no charge is made;
23. Treatment as a result of Accidental Injury including setting of fractures or dislocation; Treatment for which payment is made by any governmental agency, including any foreign government;
24. Treatment for which payment is made by any governmental agency, including any foreign government;
25. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
26. Charges for onlays or crowns installed as multiple abutments;
27. Any inlay restoration;
28. Charges for dental appointments which are not kept, except as specified under the Summary of Benefits;
29. Charges for services incident to any intentionally self-inflicted injury;
30. General anesthesia including intravenous and inhalation sedation, except when Dentally Necessary.

    General anesthesia is considered Dentally Necessary when its use is:

    a) In accordance with generally accepted professional standards; and

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

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

    Patient apprehension or patient anxiety will not constitute Dental Necessity.

    A contracted Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Dental Necessity;
31. Removal of 3rd molar (wisdom) teeth other than for Dental Necessity. Dental Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not Dentally Necessary;
32. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;
33. Any service, procedure, or supply which is received or started prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have started is defined as follows:

    a) For full dentures or partial dentures: on the date the final impression is taken,

    b) For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared,

    c) For root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex,

    d) For periodontal surgery: on the date the surgery is actually performed,

    e) For all other services: on the date the service is performed.
34. For services provided by an individual or entity that is not licensed or certified by the state to provide Dental Care Ser-

vices, or is not operating within the scope of such license or certification, except as specifically stated herein;

35. Charges for saliva and bacterial testing when caries management procedures D0601, D0602, and D0603 are performed;

36. Any and all Implant services that have not received prior authorization and approval by a contracted Dental Plan Administrator if your Plan provides special Implant Benefits. Implants that are used as an abutment, double abutment, or bone anchor to support or hold a fixed bridge, orthodontic appliance, removable prosthesis, or oral-maxillofacial prosthesis are not covered.

Orthodontic Limitations & Exclusions

1. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
2. Charges for services in connection with orthodontia when rendered by a Non-Plan Dentist;
3. Treatment in progress (after banding) at inception of eligibility;
4. Surgical Orthodontics (including extraction of teeth) incidental to Orthodontic treatment;
5. Treatment for myofunctional therapy;
6. Changes in treatment necessitated by an accident;
7. Treatment for TMJ (Temporomandibular Joint) disorder or dysfunction;
8. Special Orthodontic appliances, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be Cosmetic;
9. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
10. Treatment exceeding twenty-four (24) months except for treatment prior approved by Blue Shield as Dentally Necessary;
11. In the event of a Member's loss of coverage for any reason, if at the time of loss of coverage the Member is still receiving Orthodontic treatment during the twenty-four (24) month treatment period, the Member and not a Dental Plan Administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's billed charges, prorated for the number of months remaining;
12. If the Member is reinstated after cancellation, there are no Orthodontic Benefits for treatment begun prior to his or her reinstatement effective date;
13. There is a twelve (12) month waiting period before beginning Orthodontic treatment;
14. If the Member elects to use the Invisalign® system, Member pays both the Member cost for "standard" Orthodontic system of brackets and wire, and the additional costs for the Invisalign® system beyond what Blue Shield and Member would pay for "standard" Orthodontic system of brackets and wires. See the Grievance Process for information on filing a grievance and your right to seek assistance from the Department of Managed Health Care.

Dental Necessity Exclusion

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

Alternate Benefits Provision

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the Plan will pay Benefits based upon the less costly service.

General Limitations

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

1. One (1) in six (6) months:
   a) Periodic oral exam;
   b) Routine prophylaxis;
   c) Fluoride treatment;
   d) Bitewing x-rays (two (2) sets of single films or one (1) set of two (2) films);
   e) Recementations if the crown was provided by other than the original Dentist; not eligible if the Dentist is doing the recementation of a service he/she provided within twelve (12) months; and
   f) Periodontal maintenance.
2. One (1) in twelve (12) months:
   a) Denture (complete and partial) relines;
   b) Oral cancer screening;
   c) Bitewing x-rays, maximum four (4) per occurrence; and
   d) Topical fluoride varnish (coverage limited to three (3) applications, when used as a therapeutic application in patients with a moderate-to-high carries risk).
3. One (1) in twenty-four (24) months:
   a) Gingival flap surgery per quad;
   b) Sealants;
   c) Diagnostic casts; and
   d) Occlusal guards.
4. One (1) in thirty-six (36) months:
   a) Mucogingival surgery per area;
   b) Osseous surgery per quad;

c) Full mouth debridement;

d) Gingivectomy per quad;

e) Gingivectomy per tooth;

f) Bone replacement grafts for periodontal purposes;

g) Guided tissue regeneration for periodontal purposes;

h) Full mouth series and panoramic x-rays;

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

j) Panoramic film.

5. One (1) in five (5) years:

   a) Single crowns and onlays;

   b) Single post and core buildups;

   c) Crown buildup including pins;

   d) Prefabricated post and core;

   e) Cast post and core in addition to crown;

   f) Complete dentures;

   g) Partial dentures;

   h) Fixed partial denture (bridge) pontics;

   i) Fixed partial denture (bridge) abutments;

   j) Abutment post and core buildups.

6. Space maintainers – only eligible for Members through age fifteen (15) when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop;

7. Sealants – one (1) per tooth per two-year period through age eleven (11) on permanent first and second molars;

8. Child fluoride (including fluoride varnish) and child prophylaxis – one (1) per six (6) month period through age sixteen (16);

9. Topical fluoride varnish; therapeutic application for moderate to high caries risk patients – three (3) in a twelve (12) month period;

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

11. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the Dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than three (3) teeth missing in one (1) 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;

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

    a) Three (3) or more surgical extractions;

    b) Any number of Dentally Necessary impactions;

    c) Full mouth or arch alveoloplasty;

    d) Surgical root recovery from sinus;

    e) Medical problem contraindicates local anesthesia;

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

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

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

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

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

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

17. Scaling and root planing – covered once for each of the four quadrants of the mouth in a twenty-four (24) month period. Scaling and root planing is limited to two (2) quadrants of the mouth per visit.

Exception for Other Coverage

A Plan Dentist may seek reimbursement from other third party payors 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 of California 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 paid by Blue Shield of California or a contracted Dental Plan Administrator on a fee-for-service basis 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 thirty 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate and execute any forms or documents needed to 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 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.

Reinstatement, Cancellation and Rescission Provisions

Reinstatement

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

Cancellation Without Cause

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

Cancellation for Non-Payment of Dues – Notices

Blue Shield of California may cancel the Dental Service Plan for non-payment of Dues. If the Subscriber fails to pay the required Dues when due, coverage will end 30 days after the date for which Dues are due. You will be liable for all Dues accrued while this Plan continues in force including those accrued during the 30 day grace period. Blue Shield of California will mail you a Notice of Cancellation for Nonpayment of Premiums and Grace Period.

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

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

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

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

Right of Cancellation

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

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

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

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

Termination of Benefits

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

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

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

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

Commencement or Termination of Coverage

Whenever this Agreement provides for a date of commencement or termination of any part of 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.

Limitations for Duplicate Coverage

When you are eligible for Medi-Cal

Your Blue Shield of California Plan always provides Benefits first. Medi-Cal always provides Benefits last.

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 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 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 Plan will equal, but not exceed, what Blue Shield of California or a 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 Dental Plan Administrator's Allowable Amount).

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

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 a contracted Dental Plan Administrator based upon an objective review that is consistent with professionally recognized standards of care.

If a Member receives Emergency Services outside of California, you will be reimbursed up to the maximum amount listed under the Out-of-Network column in section entitled "Summary of Benefits and Member Copayments". The Member will be responsible for the remainder of the Dentist's billed charges. Whenever possible, the Member should ask the Dentist to bill the Plan directly.

Payment or reimbursement of Emergency Services provided to a Member will be made after a Dental Plan Administrator receives documentation of the charges incurred and upon approval by a Dental Plan Administrator of those charges set forth. Except for Emergency Services, as noted above, a Member will be responsible for full payment of dental services rendered outside of California. A Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

Dues

Monthly Dues are stated in the Appendix. Blue Shield of California offers a variety of options and methods by which you may pay your Dues.

Please call Customer 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 of California a tax or license fee which is calculated upon base Dues or Blue Shield of California'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 monthly Dues for this plan.

General Provisions

Commencement or Termination of Coverage

Whenever this Agreement provides for a date of commencement or termination of any part of 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.

Claims and Services Review

Blue Shield of California 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 of California or a Dental Plan Administrator may use the service of Dentist consultants, peer review committees or professional societies, and other consultants to evaluate claims.

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of Benefits in excess of the Benefits provided by the health plan,

payment of amounts that are the responsibility of the Subscriber or Member (Deductibles, Copayment amounts, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

Liability of Subscribers in the Event of Non-Payment by Blue Shield of California

In accordance with Blue Shield of California's established policies, and by statute, every contract between a Dental Plan Administrator and its Plan Dentists stipulates that the Subscriber shall not be responsible to the Plan Dentist for compensation for any services to the extent that they are provided in the Subscriber's medical policy. When services are provided by a Plan Dentist, the Subscriber is responsible for any applicable Deductible or Copayment amounts, and charges in excess of Benefit maximums.

If services are provided by a Non-Plan Dentist, the Subscriber is responsible for any amount Blue Shield of California does not pay.

When a Benefit specifies a maximum allowance and the Plan's maximum has been reached, the Subscriber is responsible for any charges above the Benefit maximum amounts.

Entire Agreement: Changes

This Agreement, including the appendices, constituted the entire Agreement between parties. Any statement made by a Member shall, in the absence of fraud, be deemed a representation and not a warranty. No changes in this Agreement shall be valid unless approved by a corporate officer of Blue Shield of California and a written endorsement 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 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 change.

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

Grace Period

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

Time Limit on Certain Defenses

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

Legal Actions

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

Choice of Providers

Under this Plan, you have a free choice of any licensed Dentist including such providers outside of California.

Facilities (Plan Dentists)

The names of Plan Dentists in your area may be obtained by contacting a Dental Plan Administrator at 1-888-679-8928.

Notices

Any notice required by this Agreement may be delivered by United States mail, postage pre-paid. Notice to the Subscriber may be mailed to the address appearing on the records of Blue Shield of California and notice to Blue Shield of California may be mailed to:

Blue Shield of California
50 Beale Street
San Francisco, CA 94105

Independent Contractors

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

Endorsements and Appendices

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

Identification Cards

Identification cards will be issued by Blue Shield of California to all Subscribers.

Possession of a Blue Shield of California identification card confers no right to services or other Benefits of this Agreement. To be entitled to services, the Member must be a Subscriber who has maintained enrollment under the terms of this Agreement.

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 addi-

tion, 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 upon Blue Shield of California must be served upon a corporate officer of Blue Shield of California.

Non-Assignability

Coverage or any Benefits of the Blue Shield of California dental plans are not assignable without the written consent of Blue Shield of California.

The coverage and Benefits of the Blue Shield of California dental plan are assignable to Plan Dentists and Non-Plan Dentists.

Utilization Review

State law requires that health plans disclose to Subscribers and health plan providers the process used to authorize or deny health care services under the plan. Blue Shield of California has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code. To request a copy of the document describing this Utilization Review process, call the Customer Service Department at 1-888-679-8928.

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 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.

Dental Customer Services

Questions about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced should be directed to your Dental Customer Service at the phone number or address which appear below:

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

Dental Customer Service can answer many questions over the telephone.

If the grievance involves a Non-Plan Provider, the Subscriber should contact the appropriate Blue Shield Customer Service Department shown on the last page of this Evidence of Coverage and Health Service Agreement.

Note: A Dental Plan Administrator has established a procedure for our Subscribers to request an expedited decision. A Subscriber, physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. A Dental Plan Administrator shall make a decision and notify the Subscriber and physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the Dental Customer Service Department at the number listed above.

Grievance Process

Blue Shield of California has established a grievance procedure for receiving, resolving and tracking Subscribers' grievances.

Members, a designated representative, or a provider on behalf of the Member, may contact the Dental Member Service Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Members may contact the Dental Member Service Department at the telephone number as noted below. If the telephone inquiry to the Dental Member Service 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 Service 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 Service Department. If the Member wishes, the Dental Member Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to a Dental Plan Administrator at the address provided below. The Member may also submit the grievance to the Dental Member Service Department online by visiting http://www.blueshieldca.com.

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

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

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

Department of Managed Health Care Review

The California Department of Managed Health Care (the Department) is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at 1-888-679-8928 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 of California will not disclose this information without your authorization, except as permitted by law.

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

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

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

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

Toll-Free Telephone Number:
1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@BlueShieldca.com

Access to Information

Blue Shield of California may need information from medical providers, from other carriers or other entities, or from you, in order to administer Benefits and eligibility provisions of this Agreement. You agree that any provider or entity can disclose to Blue Shield of California that information that is reasonably needed by Blue Shield of California. You agree to assist Blue Shield of California in obtaining this information, if needed, (including signing any necessary Authorizations) and to cooperate by providing Blue Shield of California with information in your possession. Failure to assist Blue Shield of California in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield of California will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Public Policy Participation Procedure

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

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

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

Sr. Manager, Regulatory Filings
Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Phone: 1-415-229-5065

Procedure

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

Definitions

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

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

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

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

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

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

Calendar Year – a period beginning at 12:01 A.M. on January 1 and ending at 12:01 A.M. January 1 of the next year.

Close Relative – the spouse, Domestic Partner, child, brother, sister or parent of a Subscriber or Dependent.

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

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

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

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

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

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

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

1. Services which are of Dental Necessity include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards which, as determined by a 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 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 Plan Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Plan Dentists.

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

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

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

Dependent –

1. A Subscriber's legally married spouse or Domestic Partner who is:

    a. A Resident of California (unless a full-time student); and

    b. Not covered for Benefits as a Subscriber; and

    c. Not legally separated from the Subscriber; or

2. A Subscriber's Domestic Partner who is:

    a. Not covered for Benefits as a Subscriber; and

    b. A Resident of California.

3. A child of, adopted by, or in legal guardianship of the Subscriber, spouse or Domestic Partner, who is unmarried and is not in a domestic partnership. This category includes any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber and who is less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by the Plan as a Dependent and has maintained membership in accordance with the contract.

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

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

    a) the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

    b) the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and

    c) thereafter, certification of continuing disability and dependency from a physician must be submitted to Blue Shield on the following schedule:

        (i) within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and

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

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

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

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

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

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

Experimental or Investigational in Nature – any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical/dental standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical/dental standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

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

Member – either a Subscriber or Dependent.

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

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

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

Orthodontics (Orthodontic) – Dental Care Services specifically related to necessary services for the treatment for malocclusion and the proper alignment of teeth.

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

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

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

Plan – the Blue Shield of California Enhanced Dental PPO 25/500.

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

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

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

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

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

Service Area – that geographic area served by the Plan.

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

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

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

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

សេវាកម្មភាសាឥតគិតថ្លៃ ។ 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.

Jeff Smith, Vice President and General Manager
Individual and Family Plans
Blue Shield of California

Dental Customer Service Telephone Numbers:

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

Blue Shield of California
1-800-431-2809

Dental Customer Service Correspondence Address:

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

Claims for all Covered Services should be sent to:

Blue Shield of California
P. O. Box 2722590
Chico, CA 95927-2590

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