

Summary of Benefits

**Group Dental Plan
DHMO Plan**

Dental HMO Basic

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC)¹. Please read both documents carefully for details.

Dental Provider Network:

DHMO Network

This Plan uses a specific network of dental care providers, called the DHMO provider network. Dentists in this network are called Participating Dentists. You must select a Participating Dentist from this network to provide your primary dental care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductible (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Dentist³
Calendar Year Deductible	<i>Individual coverage</i>	\$0 per individual
	<i>Family coverage</i>	\$0

Calendar Year Benefit Maximum

This Plan pays up to the maximum payment amount as listed for Covered Services and supplies per year.

	When using a Participating Dentist³
Calendar Year Benefit Maximum	No maximum

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services.

Waiting period	No waiting period
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No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
	Diagnostic services (exams and x-rays)	
D0120	Periodic oral evaluation	\$0
D0140	Limited oral evaluation – problem focused	\$0
D0145	Oral evaluation for a patient under three years of age	\$0
D0150	Comprehensive oral evaluation	\$0
D0160	Detailed and extensive oral evaluation – problem focused	\$0
D0170	Re-evaluation – limited, problem focused (not post-operative visit)	\$0
D0180	Comprehensive periodontal evaluation	\$0
D0190	Screening of a patient	\$0
D0191	Assessment of a patient	\$0
D0210	Intraoral complete series radiographs - includes bitewings (once every 36 months)	\$0
D0220	Intraoral periapical radiograph – first film	\$0
D0230	Intraoral periapical radiograph – each additional film	\$0
D0240	Intraoral occlusal radiograph	\$0
D0270	Bitewing radiograph – single film	\$0
D0272	Bitewing radiograph – two films	\$0
D0273	Bitewing radiograph – three films	\$0
D0274	Bitewing radiograph – four films	\$0
D0330	Panoramic radiograph film (once every 36 months)	\$0
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	\$0
D0601	Caries risk assessment and documentation, with a finding of low risk	\$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	\$0
D0603	Caries risk assessment and documentation, with a finding of high risk	\$0
D0701	Panoramic radiographic - image capture only	\$0
D0702	2-D cephalometric radiographic image – image capture only	\$0
D0706	Intraoral – occlusal radiographic image – image capture only	\$0
D0707	Intraoral – periapical radiographic image – image capture only	\$0
D0708	Intraoral – bitewing radiographic image – image capture only Image axis may be horizontal or vertical	\$0
D0709	Intraoral – complete series of radiographic images – image capture only	\$0
	Preventive services (cleanings and fluoride)	
D1110	Prophylaxis – adult age 17 and older (twice every consecutive 12 months)	\$0

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
D1110	Prophylaxis – adult age 17 and older (additional within the consecutive 12-month period)	\$45
D1110	Enhanced dental cleaning for pregnant women	\$0
D1120	Prophylaxis – child through age 16 (twice every consecutive 12 months)	\$0
D1120	Prophylaxis – child through age 16 (additional within the consecutive 12-month period)	\$35
D1206	Topical application of fluoride varnish	\$0
D1208	Topical application of fluoride – excluding varnish	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant – per tooth	\$0
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth – child through age 18	\$0
D1510	Space maintainer – fixed - unilateral - per quadrant	\$40
D1516	Space maintainer – fixed – bilateral, maxillary	\$40
D1517	Space maintainer – fixed – bilateral, mandibular	\$40
D1520	Space maintainer – removable - unilateral - per quadrant	\$40
D1526	Space maintainer – removable – bilateral, maxillary	\$40
D1527	Space maintainer – removable – bilateral, mandibular	\$40
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$40
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	\$40
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	\$40
D1556	Removal of fixed unilateral space maintainer – per quadrant	\$20
D1557	Removal of fixed bilateral space maintainer – maxillary	\$20
D1558	Removal of fixed bilateral space maintainer – mandibular	\$20
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant -under age 6 (once per lifetime)	\$5
	Minor Restorative services (fillings)	
D2140	Amalgam – one surface, primary or permanent	\$20
D2150	Amalgam – two surfaces, primary or permanent	\$40
D2160	Amalgam – three surfaces, primary or permanent	\$60
D2161	Amalgam – four or more surfaces, primary or permanent	\$80
D2330	Resin-based composite – one surface, anterior	\$20
D2331	Resin-based composite – two surfaces, anterior	\$40
D2332	Resin-based composite – three surfaces, anterior	\$60
D2335	Resin-based composite – four or more surfaces or involving incisal angle, anterior	\$80
D2390	Resin-based composite – crown, anterior	\$150

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
D2391	Resin-based composite – one surface, posterior	\$75/tooth
D2392	Resin-based composite – two surfaces, posterior	\$90
D2393	Resin-based composite – three surfaces, posterior	\$115
D2394	Resin-based composite – four or more surfaces, posterior	\$140
	Major Restorative services (crowns)	
D2542	Onlay – metallic – two surfaces	\$325
D2543	Onlay – metallic – three surfaces	\$325
D2544	Onlay – metallic – four or more surfaces	\$325
D2642	Onlay – porcelain/ceramic – two surfaces	\$390
D2643	Onlay – porcelain/ceramic – three surfaces	\$410
D2644	Onlay – porcelain/ceramic – four or more surfaces	\$430
D2662	Onlay – resin-based composite – two surfaces	\$330
D2663	Onlay – resin-based composite – three surfaces	\$350
D2664	Onlay – resin-based composite – four or more surfaces	\$380
D2710	Crown – resin-based composite – indirect	\$210/crown
D2720	Crown – resin with high noble metal	\$395/crown ⁶
D2721	Crown – resin with predominantly base metal	\$330/crown ⁶
D2722	Crown – resin with noble metal	\$360/crown ⁶
D2740	Crown – porcelain/ceramic	\$350/crown ⁶
D2750	Crown – porcelain fused to high noble metal	\$350/crown ⁶
D2751	Crown – porcelain fused to predominantly base metal	\$350/crown ⁶
D2752	Crown – porcelain fused to noble metal	\$350/crown ⁶
D2753	Crown – porcelain fused to titanium and titanium alloys	\$350/crown ⁶
D2780	Crown – 3/4 cast high noble metal	\$350/crown ⁶
D2781	Crown – 3/4 cast predominantly base metal	\$350/crown ⁶
D2782	Crown – 3/4 cast noble metal	\$350/crown ⁶
D2783	Crown – 3/4 porcelain/ceramic	\$350/crown ⁶
D2790	Crown – full cast high noble metal	\$350/crown ⁶
D2791	Crown – full cast predominantly base metal	\$350/crown ⁶
D2792	Crown – full cast noble metal	\$350/crown ⁶
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$45
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$45
D2920	Re-cement or re-bond crown	\$15
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	\$95
D2930	Prefabricated stainless steel crown – primary tooth	\$30

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
D2931	Prefabricated stainless steel crown – permanent tooth	\$95
D2932	Prefabricated resin crown	\$100
D2933	Prefabricated stainless steel crown with resin window	\$100
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$100
D2940	Protective restoration	\$48/tooth
D2950	Core buildup, including any pins when required	\$118
D2951	Pin retention – per tooth, in addition to restoration	\$25/tooth
D2952	Post and core in addition to crown – indirectly fabricated	\$165
D2953	Each additional indirectly fabricated post – same tooth	\$100/tooth
D2954	Prefabricated post and core in addition to crown	\$140
D2955	Post removal	\$0
D2957	Each additional prefabricated post – same tooth	\$78/tooth
D2980	Crown repair necessitated by restorative material failure	\$121
D2981	Inlay repair necessitated by restorative material failure	\$48
D2982	Onlay repair necessitated by restorative material failure	\$73
	Endodontic services (root canals)	
D3110	Pulp cap – direct (excluding final restoration)	\$20
D3120	Pulp cap – indirect (excluding final restoration)	\$20
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	\$35/tooth
D3221	Pulpal debridement – primary and permanent tooth	\$60
D3310	Endodontic therapy – anterior tooth (excluding final restoration)	\$175
D3320	Endodontic therapy – premolar tooth (excluding final restoration)	\$250
D3330	Endodontic therapy – molar tooth (excluding final restoration)	\$355
D3331	Treatment of root canal obstruction – non-surgical access	\$40
D3332	Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth	\$130
D3346	Retreatment of previous root canal therapy – anterior	\$175
D3347	Retreatment of previous root canal therapy – bicuspid	\$350
D3348	Retreatment of previous root canal therapy – molar	\$525
D3410	Apicoectomy – anterior – first root	\$75
D3421	Apicoectomy – premolar – first root	\$75
D3425	Apicoectomy – molar – first root	\$75
D3426	Apicoectomy – each additional root	\$75
D3430	Retrograde filling – per root	\$113
D3450	Root amputation – per root	\$125

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
D3471	Surgical repair of a root resorption – anterior – first root	\$75
D3472	Surgical repair of a root resorption – molar – for surgery on root of premolar tooth – first root. Does not include placement of restoration.	\$75
D3473	Surgical repair of a root resorption – molar – for surgery on root of molar tooth – first root. Does not include placement of restoration.	\$75
D3920	Hemisection, including any root removal (not including root canal therapy)	\$125
D3950	Canal preparation and fitting of preformed dowel or post	\$0
	Periodontic services (gum disease)	
D4210	Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces – per quadrant	\$200
D4211	Gingivectomy/gingivoplasty – one to three contiguous teeth or tooth bounded spaces – per quadrant	\$40
D4212	Gingivectomy/gingivoplasty – to allow access for restorative procedure – per tooth	\$0
D4240	Gingival flap procedure, including root planing – four or more teeth – per quadrant	\$190
D4241	Gingival flap procedure, including root planing – one to three teeth – per quadrant	\$138
D4260	Osseous surgery, including elevation of a full thickness flap and closure – four or more contiguous teeth or tooth bounded spaces – per quadrant	\$275
D4261	Osseous surgery, including elevation of full thickness flap and closure – one to three contiguous teeth or tooth bounded spaces – per quadrant	\$138
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	\$275
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	\$135
D4266	Guided tissue regeneration – resorbable barrier – per site	\$215
D4267	Guided tissue regeneration – non-resorbable barrier – per site, includes membrane removal	\$225
D4270	Pedicle soft tissue graft procedure	\$350
D4273	Autogenous connective tissue graft procedure, including donor and recipient surgical sites – first tooth – implant or edentulous tooth position in graft	\$450
D4277	Free soft tissue graft procedure, including recipient and donor surgical sites – first tooth, implant, or edentulous tooth position in graft	\$375
D4278	Free soft tissue graft procedure, including recipient and donor surgical sites – each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$225
D4341	Periodontal scaling and root planing – four or more teeth – per quadrant	\$75
D4342	Periodontal scaling and root planing – one to three teeth – per quadrant	\$38

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (11 years of age and older; once per 12 months)	\$5/entire mouth
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	\$75
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue – per tooth	\$48
D4910	Periodontal maintenance	\$45
	Removable prosthetic services (dentures)	
D5110	Complete denture – maxillary	\$400/denture
D5120	Complete denture – mandibular	\$400/denture
D5130	Immediate denture – maxillary	\$400/denture
D5140	Immediate denture – mandibular	\$400/denture
D5211	Maxillary partial denture – resin base, including retentive/clasping materials, rests and teeth	\$400/denture
D5212	Mandibular partial denture – resin base, including retentive/clasping materials, rests and teeth	\$400/denture
D5213	Maxillary partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests and teeth	\$400/denture ⁶
D5214	Mandibular partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests and teeth	\$400/denture ⁶
D5225	Maxillary partial denture – flexible base, including retentive/clasping materials, rests and teeth	\$400/denture
D5226	Mandibular partial denture – flexible base, including retentive/clasping materials, rests and teeth	\$400/denture
D5282	Removable unilateral partial denture – one-piece cast metal, including retentive /clasping materials and teeth, maxillary	\$400/denture ⁶
D5283	Removable unilateral partial denture – one-piece cast metal, including retentive/clasping materials and teeth, mandibular	\$400/denture ⁶
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials and teeth) – per quadrant	\$400/denture
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials and teeth) – per quadrant	\$400/site
D5410	Adjust complete denture – maxillary	\$0
D5411	Adjust complete denture – mandibular	\$0
D5421	Adjust partial denture – maxillary	\$40/denture
D5422	Adjust partial denture – mandibular	\$40/denture
D5511	Repair broken complete denture base – mandibular	\$85 ⁷
D5512	Repair broken complete denture base – maxillary	\$85 ⁷

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
D5520	Replace missing or broken teeth – complete denture – each tooth	\$75 ⁷
D5611	Repair resin partial denture base – mandibular	\$95 ⁷
D5612	Repair resin partial denture base – maxillary	\$95 ⁷
D5621	Repair cast partial framework – mandibular	\$100 ⁷
D5622	Repair cast partial framework – maxillary	\$100 ⁷
D5630	Repair or replace broken retentive/clasping materials – per tooth	\$100 ⁷
D5640	Replace broken teeth – per tooth	\$75 ⁷
D5650	Add tooth to existing partial denture	\$85 ⁷
D5660	Add clasp to existing partial denture – per tooth	\$85 ⁷
D5670	Replace all teeth and acrylic on cast metal framework – maxillary	\$270 ⁷
D5671	Replace all teeth and acrylic on cast metal framework – mandibular	\$270 ⁷
D5710	Rebase – complete maxillary denture	\$125
D5711	Rebase – complete mandibular denture	\$125
D5720	Rebase – partial maxillary denture	\$125
D5721	Rebase – partial mandibular denture	\$125
D5730	Reline complete maxillary denture – direct	\$125/denture ⁸
D5731	Reline complete mandibular denture – direct	\$125/denture ⁸
D5740	Reline maxillary partial denture – direct	\$125/denture ⁸
D5741	Reline mandibular partial denture – direct	\$125/denture ⁸
D5750	Reline complete maxillary denture – indirect	\$150/denture ⁸
D5751	Reline complete mandibular denture – indirect	\$150/denture ⁸
D5760	Reline maxillary partial denture – indirect	\$150/denture ⁸
D5761	Reline mandibular partial denture – indirect	\$150/denture ⁸
D5850	Tissue conditioning – maxillary	\$30/denture unit
D5851	Tissue conditioning – mandibular	\$30/denture unit
	Bridges, abutments or pontic services	
D6205	Pontic – indirect resin-based composite	\$310/tooth ⁶
D6210	Pontic – cast high noble metal	\$350 ⁶
D6211	Pontic – cast predominantly base metal	\$350 ⁶
D6212	Pontic – cast noble metal	\$350 ⁶
D6240	Pontic – porcelain fused to high noble metal	\$350 ⁶
D6241	Pontic – porcelain fused to predominantly base metal	\$350 ⁶
D6242	Pontic – porcelain fused to noble metal	\$350 ⁶
D6243	Pontic – porcelain fused to titanium and titanium alloys	\$350 ⁶
D6245	Pontic – porcelain/ceramic	\$350 ⁶

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
D6250	Pontic – resin with high noble metal	\$350 ⁶
D6251	Pontic – resin with predominantly base metal	\$350 ⁶
D6252	Pontic – resin with noble metal	\$350 ⁶
D6545	Retainer – cast metal for resin bonded fixed prosthesis	\$150 ⁶
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	\$215 ⁶
D6608	Retainer only – porcelain/ceramic – two surfaces	\$350 ⁶
D6609	Retainer only – porcelain/ceramic – three or more surfaces	\$350 ⁶
D6610	Retainer only – cast high noble metal – two surfaces	\$350 ⁶
D6611	Retainer only – cast high noble metal – three or more surfaces	\$350 ⁶
D6612	Retainer only – cast predominantly base metal – two surfaces	\$350 ⁶
D6613	Retainer only – cast predominantly base metal – three or more surfaces	\$350 ⁶
D6614	Retainer only – cast noble metal – two surfaces	\$350 ⁶
D6615	Retainer only – cast noble metal – three or more surfaces	\$350 ⁶
D6710	Retainer crown – indirect resin-based composite	\$350 ⁶
D6720	Retainer crown – resin with high noble metal	\$350 ⁶
D6721	Retainer crown – resin with predominantly base metal	\$350 ⁶
D6722	Retainer crown – resin with noble metal	\$350 ⁶
D6740	Retainer crown – porcelain/ceramic	\$350 ⁶
D6750	Retainer crown – porcelain fused to high noble metal	\$350 ⁶
D6751	Retainer crown – porcelain fused to predominantly base metal	\$350 ⁶
D6752	Retainer crown – porcelain fused to noble metal (anterior and premolar teeth only)	\$350 ⁶
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	\$350 ⁶
D6780	Retainer crown – 3/4 cast high noble metal	\$350 ⁶
D6781	Retainer crown – 3/4 cast predominantly base metal	\$350 ⁶
D6782	Retainer crown – 3/4 cast noble metal	\$350 ⁶
D6783	Retainer crown – 3/4 porcelain/ceramic (anterior and premolar teeth only)	\$350 ⁶
D6784	Retainer crown – 3/4 titanium and titanium alloys	\$350 ⁶
D6790	Retainer crown – full cast high noble metal	\$350 ⁶
D6791	Retainer crown – full cast predominantly base metal	\$350 ⁶
D6792	Retainer crown – full cast noble metal	\$350 ⁶
D6930	Re-cement or re-bond fixed partial denture	\$30
D6980	Fixed partial denture repair necessitated by restorative material failure	\$30 ⁷
	Oral surgery services	
D7111	Extraction – coronal remnants – primary tooth	\$20/tooth

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
D7140	Extraction – erupted tooth or exposed root, including elevation and/or forceps removal	\$40/tooth
D7210	Extraction – erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	\$75/tooth
D7220	Removal of impacted tooth – soft tissue	\$100/tooth
D7230	Removal of impacted tooth – partially bony	\$150/tooth
D7240	Removal of impacted tooth – completely bony	\$225/tooth
D7241	Removal of impacted tooth – completely bony with unusual surgical complications	\$250
D7250	Removal of residual tooth roots – cutting procedure	\$75
D7251	Coronectomy – intentional partial tooth removal	\$94
D7260	Oroantral fistula closure	\$350
D7285	Incisional biopsy of oral tissue – hard – bone or tooth	\$76 ⁷
D7286	Incisional biopsy of oral tissue – soft	\$60 ⁷
D7287	Exfoliative cytological sample collection	\$60
D7288	Brush biopsy – transepithelial sample collection	\$30
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	\$75/quadrant
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	\$38/quadrant
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	\$75/quadrant
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	\$38/quadrant
D7471	Removal of lateral exostosis – maxilla or mandible	\$263
D7472	Removal of torus palatinus	\$315
D7473	Removal of torus mandibularis	\$300
D7510	Incision and drainage of abscess – intraoral soft tissue	\$98
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated, includes drainage of multiple facial spaces	\$139
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$170
D7961	Buccal/labial frenectomy (frenulectomy)	\$188
D7962	Lingual frenectomy (frenulectomy)	\$188/visit
D7963	Frenuloplasty	\$205
D7970	Excision of hyperplastic tissue – per arch	\$125
D7971	Excision of pericoronal gingiva	\$100
D7972	Surgical reduction of fibrous tuberosity	\$301

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating ³ Dentist
	Orthodontic services	
D8070	Comprehensive Orthodontic treatment of the transitional dentition – (child through age 13)	\$2,350 ⁹
D8080	Comprehensive Orthodontic treatment of the adolescent dentition	\$2,350 ⁹
D8090	Comprehensive Orthodontic treatment of the adult dentition	\$2,650 ⁹
D8210	Removable appliance therapy	\$360 ⁹
D8220	Fixed appliance therapy	\$406 ⁹
D8660	Pre-Orthodontic treatment examination to monitor growth and development	\$250/visit ⁹
D8670	Periodic Orthodontic treatment visit	\$0 ⁹
D8680	Orthodontic retention, including removal of appliances, construction and placement of retainer(s)	\$250/retainer ⁹
D8696	Repair of Orthodontic appliance – maxillary	\$88 ⁹
D8697	Repair of orthodontic appliance – mandibular	\$88 ⁹
	Adjunctive general services	
D9110	Palliative emergency treatment of dental pain – minor procedure	\$20/visit ¹⁰
D9120	Fixed partial denture sectioning	\$37
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0
D9211	Regional block anesthesia	\$0
D9212	Trigeminal division block anesthesia	\$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0
D9220	General anesthesia - first 30 minutes	\$0
D9221	General anesthesia - each additional 15 minutes	\$0
D9241	IV sedation – first 30 minutes	\$0
D9242	IV sedation – each additional 15 minutes	\$0
D9310	Consultation – diagnostic consultation provided by dentist or physician other than requesting dentist or physician (as necessary)	\$0
D9430	Office visit for observation during regularly scheduled hours – no other services performed	\$15
D9440	Office visit – after regularly scheduled hours	\$40
D9910	Application of desensitizing medicament	\$0
D9942	Repair and/or reline of occlusal guard	\$45
D9951	Occlusal adjustment – limited	\$60/entire mouth
D9952	Occlusal adjustment – complete	\$125/entire mouth
	Other services	
D9999	Failed Appointment without 24-hour notice – per 15 minutes of appointment time	\$20/visit

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

3 Using Participating Dentists:

Participating Dentists have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Participating Dentist, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

4 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance.

5 Dental Care Services:

All dental Benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Orthodontic Covered Services. The Copayment or Coinsurance for Orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies only if the Member remains enrolled in the Plan. All procedures performed in connection with Orthodontic treatment are payable as Orthodontic Covered Services.

Dental Care Covered Services. All Covered Services must be Medically Necessary and must be provided by the Member's Dental Center or other Participating Dentist when referred by the Member's Dental Center and Authorized by the contracted Dental Plan Administrator.

6 Metals and Porcelain:

Precious (high noble) and semi-precious (noble) metals are subject to an additional charge. If these metals are used for fillings, crowns, bridges, or prosthetic devices, they are subject to an additional charge of \$150 per unit.

Porcelain on molar crowns is subject to an additional cost of \$150 per unit.

7 Laboratory Fees:

Denture repair, biopsy, and excision Covered Services are subject to an additional charge for lab fees. The Member is responsible for paying the lab fees plus any applicable Copayment or Coinsurance for these services.

Notes

8 Denture Reline Services:

The Copayment or Coinsurance for Covered Services applies if done within six (6) months of the initial insertion of a denture. Denture relines after six (6) months of the initial insertion of a denture require the additional denture reline Copayment or Coinsurance.

9 Orthodontic Services:

Orthodontic Covered Services. The Copayment or Coinsurance for Orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

Full case fee. The full case fee for Orthodontic Covered Services includes a consultation, a treatment plan, tooth movement, and retention limited to \$250 per case. Orthodontists may charge Members separately for records.

10 Palliative Emergency Treatment:

For an emergency oral exam with palliative treatment, if the treatment includes a listed procedure, then the regular Copayment or Coinsurance applies.

Plans may be modified to ensure compliance with State and Federal requirements.

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

Phone: (844) 831-4133 (TTY: 711)

Fax: (844) 696-6070

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

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

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

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

Notice of the Availability of Language Assistance Services

Blue Shield of California

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

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

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

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

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

Baa' ákohwiindzindooígí: Díí naaltsoosish yíiniłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'í' yiidóolta'hígíí ła' nihee hółó. Díí naaltsoos aldó' t'áá Diné k'ehjí ádoolníł nínízingó bíghah. Doo ɓaąh ílínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodiłnih dóó námboo éí díí Blue Shield bee néiho'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodiłnih. (Navajo)

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

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

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

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

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

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

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

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

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

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

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

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານພັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແບ່ງຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້. ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໂທເບີ(866) 346-7198. (Laotian)