BlueCross BlueShield of Montana

Your Health Care Benefits Program

BlueCare Dental℠ 1C

THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the information at
bcbsmt.com/medicare/shop-plans/medicare-supplement

bcbsmt.com

Or call us at the phone number on your member ID card.

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

DENTALINDIVEXC2026 DPFL86NATIMTP

FOR CUSTOMER SERVICE:
Call 1-866-739-4090
or
Fax 1-888-788-3269

FOR CLAIMS, SEND TO:
Blue Cross and Blue Shield of Montana
PO Box 660247
Dallas, TX 75266-0247

FOR APPEALS, SEND TO:
Blue Cross and Blue Shield of Montana
PO Box 6227
Helena, MT 59604-6227

Blue Cross and Blue Shield of Montana
3645 Alice Street
PO Box 4309
Helena, MT 59604-4309

Access our Website at: www.bcbsmt.com

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Certain terms in this Contract are defined in the Definitions section of this Contract. Defined terms are capitalized.

THIS CONTRACT

1. **If the Member is not satisfied with this Contract for any reason, the Contract may be returned within 10 days of its delivery. The Plan will refund the amount of dues paid, thus voiding the Contract from the beginning.**
2. The Plan agrees to pay for Dental Services as outlined in this Contract subject to the following conditions:
   a. All statements made in any application for membership or any statement of health must be correct.
   b. The Plan must receive the Monthly Dues on or before the time listed on the Member's bill. **Payment of Monthly Dues is a condition precedent to coverage under this Contract.**
3. Payment by The Plan is subject to the terms, conditions and limitations of this Contract and any endorsements, amendments and/or riders.
4. Payment will only be made for Dental Services which are provided to Members on and after the Effective Date of this Contract and before the date on which this Contract terminates.

PRIVACY OF INSURANCE AND HEALTH CARE INFORMATION

It is the policy of Blue Cross and Blue Shield of Montana to protect the privacy of Members through appropriate use and handling of private information. Further, appropriate handling and security of private information may be mandated by state and/or federal law.

The Beneficiary Member may receive a copy of Blue Cross and Blue Shield of Montana's "Notice of Privacy Practices," or other information about privacy practices, by calling the telephone number or writing to the address shown on the inside cover of this Contract.

MEMBER'S RIGHTS

When requested by the Member or the Member's agent, Blue Cross and Blue Shield of Montana is required to provide a summary of a Member's coverage for a specific Dental Service when an actual charge or estimate of charges by a Dental Provider exceeds $500.

PAYMENT OF DUES

Payment of Initial Dues

The first Month's dues must be paid to and accepted by The Plan before this Contract is in effect.

Payment of Monthly Dues

Dues are payable by each Beneficiary Member in advance, in the amounts and at the times shown on the Member's bill.

Third Party Payments

Blue Cross and Blue Shield of Montana follows the premium payment process established by the Affordable Care Act in accordance with all Federal requirements. Blue Cross and Blue Shield of Montana only accepts premiums (dues) and cost-sharing payments from:

- **A.** The Member.
- **B.** The Member's family.
- **C.** Blue Cross and Blue Shield of Montana accepts premium payments from the following third-party entities on behalf of enrollees:
  - **i.** A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
  - **ii.** An Indian tribe, tribal organization or urban Indian organization; and
  - **iii.** A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.
- **D.** Blue Cross and Blue Shield of Montana may accept premium payments on behalf of enrollees from private, not-for-profit foundations, if the payments are:
  - **i.** For the entire coverage period of the enrollee's policy;
  - **ii.** Based solely on the financial status of the enrollees;
  - **iii.** Regardless of the coverage the enrollee chooses; and
  - **iv.** Regardless of the enrollee's health status.
- **E.** Blue Cross and Blue Shield of Montana may accept premium payments on behalf of enrollees from a Trust, Power of Attorney or Legal Guardian.
- **F.** Blue Cross and Blue Shield of Montana will not construe payments from an employer as impermissible third-party payments, provided such payments do not create and Employee Retirement Income Security Act (ERISA) group health plan and either:
  - **i.** The employer facilitates premium payment collection through payroll deductions or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or
  - **ii.** The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.
- **G.** Blue Cross and Blue Shield of Montana will accept payments on behalf of an enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

Blue Cross and Blue Shield of Montana does not accept premium and cost-sharing payments from any other third party. Unauthorized premium and cost-sharing payments will not be credited to the Member's account and will be refunded to the unauthorized payer. If Blue Cross and Blue Shield of Montana fails to receive payment in full from an authorized source by the end of any premium grace period, Blue Cross and Blue Shield of Montana will retroactively terminate or cancel the coverage.

Premium Payment Upon Renewal or Reenrollment

When the Member renews Blue Cross and Blue Shield of Montana coverage or reenrolls by selecting a new product, the Member will need to be current on the premium payments. Any past due premium payments for coverage that Blue Cross and Blue Shield of Montana provided, will be due at the beginning of the new plan year, in addition to current premium charges. New coverage will not be effective until all such payments are made.

Grace Period

Unless, not less than 30 days prior to the dues' due date, Blue Cross and Blue Shield of Montana has delivered to the Beneficiary Member or has mailed to the Member's last address as shown on the records of Blue Cross and Blue Shield of Montana, written notice of its intention not to renew this Contract beyond the period for which the dues have been accepted, a grace period of ten days will be granted for the payment of each Monthly Dues amount falling due after the first dues payment, during which grace period the Contract will continue in force.

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SCHEDULE OF BENEFITS

BlueCare Dental℠ 1C

Benefit Period: Calendar Year

The Benefits are subject to the Benefit Period unless otherwise specified.

Term of Contract: Monthly

DENTAL SERVICES	The Plan will pay Participating Providers	The Plan will pay Nonparticipating Providers*
Diagnostic Evaluations (Deductible waived)	80%	80%
Preventive Services (Deductible waived)	80%	80%
Diagnostic Radiographs (Deductible waived)	80%	80%
Miscellaneous Preventive Services	80%	80%
Basic Restorative Services	50%	50%
Non-Surgical Extractions	50%	50%
Adjunctive Services	50%	50%
Non-Surgical Periodontal Services	50%	50%
Endodontic Services	50%	50%
Oral Surgery Services	50%	50%
Surgical Periodontal Services	50%	50%
Major Restorative Services**	50%	50%
Prosthodontic Services**	50%	50%
Miscellaneous Restorative and Prosthodontic Services**	50%	50%
Orthodontic Services – Deductible does not apply		
Pediatric Orthodontic Services: Coverage limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria (e.g., severe, dysfunctional malocclusion) established by The Plan	50%	50%
Optional Orthodontic Services: Coverage for orthodontic conditions not meeting Medical Necessity criteria established by The Plan	50%	50%
Lifetime Maximum – Does not include Medically Necessary Pediatric Orthodontic Services	$1,000	
Deductible (In and Out-of-Network accumulate together)		
Individual	$50	
Family	$150	
Benefit Period Maximum - In and Out-of-Network accumulate together; the maximum does not apply to Orthodontic Services or to services provided to Members under the age of 19.	$1,000	
Out-of-Pocket Maximum (for Members under age 19)		
1 Child:	$450	
2+ Children:	$900	

*The Member may be responsible for any amount by which the actual charges of a nonparticipating provider exceed the Allowable Fee.

**For adults, a 12-Month waiting period applies to these services only.

PROVIDERS OF CARE FOR MEMBERS

Covered Providers may be participating providers or nonparticipating providers.

Participating Providers

Participating providers include those providers who have a contract with Blue Cross and Blue Shield of Montana and are listed in the current provider directory. The providers include Participating Blue Cross and Blue Shield of Montana Professional Providers and Participating Blue Cross and Blue Shield of Montana Facility Providers.

Nonparticipating Providers

A nonparticipating professional or facility provider does not have a contract with Blue Cross and Blue Shield of Montana.

The Member may be responsible for a greater portion of the cost for any covered services received from the nonparticipating provider than if the Member had received the same covered services from a participating provider.

How Providers are Paid by The Plan and Member Responsibility

Payment by The Plan for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield of Montana provider network.

A **participating provider** agrees to accept payment of the Allowable Fee from Blue Cross and Blue Shield of Montana for covered services, together with any Deductible and Coinsurance from the Member, as payment in full. Generally, The Plan will pay the Allowable Fee for a covered service directly to a participating provider. In any event, The Plan may, in its discretion, make payment to the Member, the provider, the Member and provider jointly, or any person, firm, or corporation who paid for the services on the Member's behalf.

Nonparticipating providers do not have to accept Blue Cross and Blue Shield of Montana payment as payment in full. Blue Cross and Blue Shield of Montana reimburses a nonparticipating provider for covered services according to the Allowable Fee. The nonparticipating provider can bill the Member for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus Deductible and Coinsurance. The Member will be responsible for the balance of the nonparticipating provider's charges after payment by Blue Cross and Blue Shield of Montana and payment of any Deductible*s* and Coinsurance.

The Plan will not pay for any services, supplies, or medications which are not covered services, or for which a Benefit maximum has been met, regardless of whether provided by a participating provider or a nonparticipating provider. The Member will be responsible for such services, supplies, or medications.

Pretreatment Estimate of Benefits and Treatment Plan

If the Member's Dentist recommends a Course of Treatment that will cost more than $300, the Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs and models and an estimate of the charges prior to beginning the Course of Treatment. The Plan will review the report and materials, taking into consideration any alternative adequate Course of Treatment, and will notify the Member and the Dentist of the estimated Benefits which will be provided under this Contract. This is not a guarantee of payment, but an estimate of the Benefits available for the proposed services to be rendered. The Plan's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and Contract requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, the Member is responsible for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by The Plan.

COMPLAINTS AND GRIEVANCES

Complaints and Grievances

The Plan has established a Complaint and Grievance process. A Complaint involves a communication from the Member expressing dissatisfaction about The Plan's services or lack of action or disagreement with The Plan's response. A Grievance will typically involve a Complaint about a provider or a provider's office and may include Complaints about a provider's lack of availability or quality of care or services received from a provider's staff.

Most problems can be handled by calling Customer Service at the number appearing on the inside cover of this Contract. The Member may also file a written Complaint or Grievance with The Plan. The fax number, email address, and mailing address of The Plan appears on the inside cover of this Contract. Written Complaints or Grievances will be acknowledged within 10 days of receipt. The Member will be notified of The Plan's response within 60 days from receipt of the Member's written Complaint or Grievance.

APPEALS

Claim Determination

The Member has the right to seek and obtain a full and fair review by The Plan of any determination of a claim or any other determination.

If a Claim Is Denied or Not Paid in Full

If the claim is denied in whole or in part, a written notice from Blue Cross and Blue Shield of Montana will be provided with the following information, if applicable:

1. The reasons for the determination;
2. A reference to the Benefit Plan provisions on which the determination is based;
3. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
4. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care provider, claim amount (if applicable), and a statement describing denial codes with their meanings. Upon request, treatment codes with their meanings and the standards used are also available;
5. An explanation of The Plan's internal review/Appeals and external review processes (and how to initiate a review/Appeal or external review) and a statement of right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/Appeal;
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's dental circumstances, if the denial was based on Dental Necessity, experimental treatment or similar Exclusion, or a statement that such explanation will be provided free of charge upon request; and
9. Contact information for consumer Appeal assistance program.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are two types of claims as defined below.

1. Pre-Service Claim is any request for Benefits or a determination with respect to which the terms of the Benefit Plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining dental care.
2. Post-Service Claim is notification in a form acceptable to The Plan that a service has been rendered or furnished. This notification must include full details of the service received, including the name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the

date of service, the claim charge, and any other information which The Plan may request in connection with services rendered.

Pre-Service Claims

Type of Notice	Timing
The Plan must notify of the claim determination (whether adverse or not):	
If The Plan received all information necessary to complete the review, within:	2 working days of receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and 3 calendar days of the request, if the claim is denied.

Post-Service Claims

Type of Notice or Extension	Timing
If the claim is incomplete, The Plan must notify the Member within:	30 days
If the Member is notified that the claim is incomplete, the Member must then provide completed claim information to The Plan within:	45 days after receiving notice
The Plan must notify the Member of any adverse claim determination:	
If the initial claim is complete, within:	30 days
After receiving the completed claim (if the initial claim is incomplete), within:	45 days
This period may be extended one time by The Plan for up to 15 days, provided that The Plan both (1) determines that such an extension is necessary due to matters beyond the control of The Plan and (2) written notification is sent prior to the expiration of the initial 30−day period, if the circumstances requiring the extension of time and the date by which The Plan expects to render a decision.	

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An “Adverse Benefit Determination” means a denial, reduction, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, or failure to provide in response to a claim, or Pre-Service Claim, or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental/investigational or not Dentally Necessary or appropriate. If an ongoing Course of Treatment had been approved by The Plan and The Plan reduces such treatment (other than by amendment or termination of the Employer’s Benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

How to Appeal an Adverse Benefit Determination

The Member has the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by The Plan. An Appeal of an Adverse Benefit Determination may be filed by the Member or a person authorized to act on the Member’s behalf. In some circumstances, a dental care provider may Appeal on his/her own behalf. The Member may orally request an Appeal if the requested Dental Service has been denied on the basis that it is not Dentally Necessary or it is experimental or investigational. If the Member believes The Plan incorrectly denied all or part of the claim, the Member may have the claim reviewed. The Plan will review its decision in accordance with the following procedure:

1. Within 180 days after the notice of an Adverse Benefit Determination, the Member may write to The Plan to request a claim review. The Plan will need to know the reasons why the Member does not agree with the Adverse Benefit Determination. Send the request to:

Blue Cross and Blue Shield of Montana
PO Box 660247
Dallas, TX 75266-0247

2. The Plan will honor telephone requests for information; however, such inquiries will not constitute a request for review.

3. In support of the claim review, the Member has the option of presenting evidence and written testimony to The Plan. The Member and/or an authorized representative may ask to review the file and any relevant documents and may submit written issues, comments and additional dental information within 180 days after the Member receives notice of an Adverse Benefit Determination or at any time during the claim review process.

The Plan will provide the Member and authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of the claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to the Member or an authorized representative sufficiently in advance of the date a final decision on Appeal is made in order to give the Member a chance to respond. If the initial Benefit determination regarding the claim is based in whole or in part on a dental judgment, the Appeal determination will be made by a Dentist associated or contracted with The Plan and/or by external advisors, but who were not involved in making the initial denial of the claim.

If the Member has any questions about the claims procedures or the review procedure, write to Blue Cross and Blue Shield of Montana or call toll-free Customer Service Helpline number shown on the inside cover of the Contract or on the Member's Identification Card.

Timing of Appeal Determinations

The Plan will render a determination of the pre-service Appeal as soon as practical, but in no event more than 30 days after the Appeal has been received by The Plan.

The Plan will render a determination of the post-service Appeal as soon as practical, but in no event more than 60 days after the Appeal has been received by The Plan.

If You Need Assistance

For questions about the claims procedures or the review procedure, write Blue Cross and Blue Shield of Montana at the address below or call at 1-866-739-4090. Customer Service is accessible from 8:00 A.M. to 6:00 P.M. Mountain Time, Monday through Friday.

Blue Cross and Blue Shield of Montana
PO Box 6227
Helena, MT 59604-6227

For additional assistance with an Appeal, a Member may also contact the Commissioner of Securities and Insurance at: Montana Commissioner of Securities and Insurance, 840 Helena Ave., Helena, MT 59601 or call 1-800-332-6148 or 406-444-2040.

If assistance is needed with the internal claims and Appeals or the external review processes that are described below, call the number on the back of the Member's Identification Card for contact information. In addition, for questions about the Appeal rights or for assistance, the Member can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Plan will notify the party filing the Appeal, the Member, and, if a clinical Appeal, any dental care provider who recommended the services involved in the Appeal, by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the Benefit Plan provisions on which the determination is based;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, treatment codes with their meanings are also available;

4. An explanation of The Plan's external review processes (and how to initiate an external review) and a statement of the Member's right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external Appeal;
5. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
6. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
7. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
8. Contact information for applicable office of consumer program assistance.

If The Plan denies the Appeal, in whole or in part, or a timely decision is not made, the Member has the right to request an external review of the claim by an independent third party, who will review the denial and issue a final decision. The external review rights are described in the How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO) section below.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)

An "Adverse Determination" means a determination by The Plan or its designated utilization review organization that a dental care service that is a covered service has been reviewed and, based upon the information provided, is determined to be experimental/investigational, or does not meet The Plan's requirements for Dental Necessity, or appropriateness and the requested service or payment for the service is therefore denied or reduced.

A "Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by The Plan at the completion of The Plan's internal review/Appeal process.

This procedure (not part of the Complaint process) pertains only to Appeals of Adverse Determinations.

Any party whose Appeal of an Adverse Determination is denied by The Plan may seek review of the decision by an IRO. At the time the Appeal is denied, The Plan will provide the Member or a designated representative or Provider of record, information on how to Appeal the denial, including the approved form, which the Member or a designated representative, or Provider of record must complete.

1. The Plan will submit dental records, names of Providers and any documentation pertinent to the decision of the IRO.
2. The Plan will comply with the decision by the IRO.
3. The Plan will pay for the independent review.

Upon request and free of charge, the Member or Member's designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or Appeal, including:

1. Information relied upon to make the decision;
2. Information submitted, considered, or generated in the course of making the decision, whether or not it was relied upon to make the decision;
3. Descriptions of the administrative process and safeguards used to make the decision;
4. Records of any independent reviews conducted by The Plan;
5. Dental judgments, including whether a particular service is experimental/investigational or not Dentally Necessary or appropriate; and
6. Expert advice and consultation obtained by The Plan in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The Appeal process does not prohibit the Member from pursuing other appropriate remedies, including injunctive relief; a declaratory judgment or other relief available under law. If the dental insurance plan is governed by the Employee Retirement Income Security Act (ERISA), the Member may have the right to bring civil action under 502(a) of ERISA.

ELIGIBILITY AND ENROLLMENT

To be eligible for enrollment, the applicant must and any Family Members for whom coverage is sought must:

1. Be a resident of the state of Montana; and
2. Complete an application.

Eligibility for this coverage will be determined by the Exchange in accordance with applicable law. For questions regarding eligibility, refer to healthcare.gov.

Applying for Coverage

An applicant may apply for dental coverage through the Exchange for himself/herself and/or any eligible Dependents. The application(s) for coverage may or may not be accepted.

No eligibility rules or variations in premium will be imposed based on health status, dental condition, claims experience, receipt of health care, dental history, genetic information, evidence of insurability, disability, or any other health status related factor. Applicants will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Variation in the administration, processes or Benefits of this Contract that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

An applicant may enroll in or change dental coverage for himself/herself and/or any eligible Dependents during one of the following enrollment periods. The Effective Date will be determined by Blue Cross and Blue Shield of Montana and the Exchange, as appropriate, depending upon the date the application is received, payment of the initial premiums no later than the day before the Effective Date of coverage and other determining factors.

Enrollment Periods

The annual enrollment periods in 2026 will be determined by the Exchange.

Annual Open Enrollment Period/Effective Date of Coverage

An applicant may apply for or change coverage in a QHP through the Exchange for the applicant and/or any Eligible Family Members during the annual open enrollment period designated by the Exchange.

When the applicant enrolls during the annual open enrollment period, the applicant's and/or any Eligible Family Members' Effective Date will be the following January 1, unless otherwise designated by the Exchange and Blue Cross and Blue Shield of Montana, as appropriate.

This section "Annual Open Enrollment Period/Effective Date of Coverage" is subject to change by the Exchange, Blue Cross and Blue Shield of Montana, and/or applicable law, as appropriate.

Special Enrollment Periods

Special enrollment periods have been designated during which the Member may apply for or change coverage in a QHP through the Exchange for himself/herself and/or any Eligible Family Members. Application must be made 60 days from the date of a special enrollment event.

Newborn

Children born to a Member after the Effective Date of the Contract will be covered for a period of 31 days beginning at the moment of birth and including the day of birth, provided the Beneficiary Member remains covered under the Contract for those 31 days. Coverage will continue for the child after the 31-day period if within 60 days the Beneficiary Member:

1. Enrolls the child through the Exchange to continue the coverage; and
2. Pays the additional dues to continue coverage for the child.

Coverage will terminate after 31 days if application to continue coverage is not received by the Exchange. If application to continue coverage is received between 32 and 60 days after the birth of the child, then coverage will be reinstated back to the date of birth. Dues must be paid for any coverage beyond the initial 31 days of coverage.

Limitations:

1. If the Beneficiary Member does not remain covered during the 31 days, the newborn will only be covered for the amount of time (during the 31 days) that the Beneficiary Member is covered.
2. However, after 31 days, coverage will not continue for any newborn child of a covered Dependent child unless the Beneficiary Member adopts the newborn child or is the legal guardian of the newborn child.

Adopted Children or Children Placed for Adoption

Children will be covered for a period of 31 days upon adoption or placement for adoption, including the date of placement, provided the Beneficiary Member remains covered under the Contract for those 31 days. Coverage will continue for the child after the 31-day period if within 60 days the Beneficiary Member:

1. Enrolls the child through the Exchange to continue the coverage; and
2. Pays the additional dues to continue coverage for the child.

Coverage will terminate after 31 days if application to continue coverage is not received by the Exchange. If application to continue coverage is received between 32 and 60 days after the adoption or placement for adoption of the child, then coverage will be reinstated back to the date of the adoption or placement for adoption of the child. Dues must be paid for any coverage beyond the initial 31 days of coverage.

Limitations:

1. If the Beneficiary Member does not remain covered during the 31 days, the child placed for adoption will only be covered for the amount of time (during the 31 days) that the Beneficiary Member is covered.
2. In the event the placement is disrupted prior to legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted.

Advance payments of any Advance Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following Month, unless the birth, adoption, or placement as a foster child or for adoption occurs on the first day of the Month.

Marriage

In the case of marriage, the Effective Date will be the date of marriage if the completed request for enrollment (application) is made through the Exchange within 60 days after the date of marriage.

Loss of Minimum Essential Coverage

In the event the Member experiences a loss of Minimum Essential Coverage, coverage will be effective on the first day of the Month following the loss of coverage. A loss of coverage does not include:

1. Termination or loss due to a failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or
2. Situations allowing for a rescission (a cancellation or discontinuance of coverage that has a retroactive effect), as determined by the Exchange.

For purposes of this section, “Minimum Essential Coverage” means Health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group or government health insurance coverage. For additional information on whether particular coverage is recognized as “Minimum Essential Coverage”, please call the customer service number on the inside cover of this document or on the back of your ID card or visit www.cms.gov.

Additional Special Enrollment Events

1. An individual gains status as a U.S. citizen(s), national(s), or lawfully present in the U.S. and gains such status.
2. Enrollment or non-enrollment in an Exchange Certified Dental Plan is unintentional, inadvertent, or erroneous as evaluated and determined by the Exchange and/or Blue Cross and Blue Shield of Montana, as appropriate.

3. An enrollee through the Exchange adequately demonstrates to the Exchange that the Exchange Certified Dental Plan in which he/she enrolled substantially violated a material provision of its contract in relation to the enrollee.
4. An individual is determined newly eligible or newly ineligible for an Advance Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether the individual already enrolled in an Exchange Certified Dental Plan.

   For purposes of this section, "Premium Tax Credit" means a refundable premium tax credit you may receive for taxable years ending after December 31, 2013, to the extent provided for under applicable law, where the credit is meant to offset all or a portion of the premium paid by you for coverage obtained through an Exchange during the preceding calendar year.
5. An individual gains access to new Exchange Certified Dental Plans as a result of a permanent move.
6. An Indian, as defined by section 4 of the Indian Health Care Improvement Act. An Indian may enroll himself/herself and any eligible Dependents in an Exchange Certified Dental Plan or change from one Exchange Certified Dental Plan to another one time per Month.
7. An individual demonstrates to the Exchange, in accordance with the guidelines issued by HHS, that he/she meets other exceptional circumstances as the Exchange may provide.
8. Loss of coverage due to voluntary or involuntary termination (other than for gross misconduct) and reduction in number of hours of employment.
9. Loss of coverage for Spouses of covered employees due to reasons that would make the employee eligible for COBRA; or loss of coverage due to the employee's death.
10. Loss of coverage for children of covered employees due to reasons that would make the employee eligible for COBRA, loss of coverage due to the employee's death, or loss of coverage due to the loss of Dependent status under the terms of The Plan.
11. Divorce or legal separation. Coverage will be effective on the first day of the Month coinciding with or the next Month following your divorce or legal separation date.
12. A Dependent is no longer considered a Dependent under The Plan because of age or work status.
13. Such other events required by applicable law.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by the Exchange and Blue Cross and Blue Shield of Montana, as appropriate.

Effective Date and Commencement of Benefits

Unless otherwise noted above, the Effective Date is as follows:

1. If an application was received on the 1st through the 14th of the Month, the Effective Date will be no later than the first day of the following Month.
2. If an application was received on the 15th through the 31st of the Month, the Effective Date will be no later than the 1st of the second following Month.

The Member is entitled to the Benefits of this Contract from the Member's Effective Date.

Transfer of Plan Membership

Transfer of Membership for Family Members

The following persons may transfer membership to their own beneficiary membership Contract if application is made in writing to The Plan within 31 days of the date of termination of their membership under this Contract.

1. A Spouse of a Beneficiary Member who was enrolled as a Family Member and ceases to be a Family Member as defined due to divorce, annulment of marriage or legal separation.
2. Children of a Beneficiary Member who were enrolled as a Family Member and cease to be a Family Member as defined.
3. Family Members of a Beneficiary Member who has died.

TERMINATION OF COVERAGE

Termination When the Beneficiary Member is No Longer Eligible for Coverage

Coverage under this Contract for the Beneficiary Member, and any Family Members, will terminate the last day of the Month following the Month in which the notice is sent by the Exchange that the Beneficiary Member is no longer eligible through the Exchange. However, a Spouse and any Family Member may be issued their own Contract. Please refer to the section entitled Transfer of Plan Membership.

Termination of Coverage of Children

Coverage will terminate the later of:

1. Midnight Mountain Time, on the last day of the Month in which a covered child reaches age 26 years. Please refer to the section entitled Transfer of Plan Membership; or
2. The last day of the Month following the Month in which the notice is sent by the Exchange that the Beneficiary Member is no longer eligible through the Exchange.

When a covered child turns age 19, he/she is no longer eligible for the Pediatric Orthodontic Services or the Out of Pocket Amount provision and the Benefit Maximums will apply.

Termination of Coverage of Spouse

Coverage will terminate the later of:

1. Midnight Mountain Time, on the last day of the Month in which the Spouse's marriage to the Beneficiary Member terminated. Please refer to the section entitled Transfer of Plan Membership; or
2. The last day of the Month following the Month in which the notice is sent by the Exchange that the Beneficiary Member is no longer eligible through the Exchange.

Termination for Nonpayment of Dues or Other Reasons

Blue Cross and Blue Shield of Montana will terminate coverage due to fraud and/or intentional misrepresentation of material fact.

If the Member's dues are not paid when due, coverage will terminate automatically at midnight, Mountain Time, on the last day of the Month for which dues are paid for the Beneficiary Member and Family Members.

Blue Cross and Blue Shield of Montana will provide notice of cancellation stating the date the cancellation will become effective, which may not be earlier than:

1. The beginning of the period for which premiums have not been paid in full if the notice of cancellation for nonpayment of premiums is mailed or delivered within 15 days after the due date of the missed premiums for that period;
2. The date of mailing or delivery of notice of cancellation for nonpayment of premiums if notice of cancellation for nonpayment of premiums is not mailed or delivered within 15 days after the premium due date for the applicable Benefit Period; or
3. 90 days after the date of mailing or delivery of the notice of cancellation or refusal to renew for any reason other than nonpayment of premiums or a material misrepresentation contained in the application.

The time frames for the notices of cancellation outlined above run concurrently with the time frames included in the section entitled "Grace Period" under Payment of Dues.

A grace period of 31 days will be granted for the payment of each premium (dues) falling due after the first premium, during which grace period the Contract shall continue in force, however, Claim Payments for covered Dental Services received during the grace period may be pended until full premium payment is made.

If the Member pays the premium in full during the 31-day grace period, then the Member may submit a claim to Blue Cross and Blue Shield of Montana for any expenses that the Member paid to providers during the grace period. See the CLAIMS section for additional information.

If a Member fails to pay premiums in full to Blue Cross and Blue Shield of Montana and/or the Exchange within 31 days of the premium due date, this Contract will automatically terminate on the last day of the coverage period for which premiums have been paid in full. Claim Payments will not be provided for covered Dental Services incurred during this 31-day grace period or thereafter unless the premiums are paid in full within this period. If coverage is terminated for non-payment of premium, any Claims received and paid for during the 31-day grace period will be billed to the Member.

For a Member receiving an Advance Premium Tax Credit, there is a three-Month grace period for paying the full premiums falling due after the first premium is paid. If full premium is not paid for the Member and any covered Family Members within one Month of the premium due date, Claim Payments for covered Dental Services received during the second and third Month's grace period under this Contract will be pended until full premium payment is received. If full payment of the premium is not received within the three-Month grace period, then coverage under this Contract will automatically terminate on the last day of the first Month of the three-Month grace period. Blue Cross and Blue Shield of Montana will not process any Claims for services after the date of termination.

Termination of Benefits on Termination of Coverage

When the membership of a Beneficiary Member and/or Family Member is terminated for any reason, the Benefits of this Contract will no longer be provided except Benefits will continue as long as the Dental Service was begun prior to the date coverage terminates and the service is completed within 30 days of the termination date and The Plan will not make payment for services provided to them after the date on which cancellation becomes effective. However, a Spouse and any Family Members may be issued their own Contract. Please refer to the section entitled Transfer of Plan Membership.

Reinstatement

If any renewal dues payment is not paid within the time granted the Member for payment, a subsequent acceptance of dues by The Plan without requiring in connection therewith an application for reinstatement, shall reinstate the Contract; provided, however, that if The Plan requires an application for reinstatement and issues a conditional receipt for the dues tendered, the Contract will be reinstated upon approval of such application by Blue Cross and Blue Shield of Montana or, lacking such approval, upon the 45th day following the date of such conditional receipt unless The Plan has previously notified the Member in writing of its disapproval of such application.

The reinstated Contract shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as began more than ten days after such date. In all other respects, the Member and The Plan shall have the same rights thereunder as they had under the Contract immediately before the due date of the defaulted dues, subject to any provision endorsed hereon or attached hereto in connection with the reinstatement.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Beneficiary Members and Family Members can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from Blue Cross and Blue Shield of Montana.

RENEWAL OF CONTRACT

Renewal of Contract by The Plan

This Contract will be renewed unless one of the following occurs:

1. Nonpayment of the required dues.
2. The Member has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact with respect to coverage of individual insureds.
3. The Member is no longer eligible for coverage in an Exchange Certified Dental Plan offered through the Exchange.
4. This Contract is terminated or is decertified as an Exchange Certified Dental Plan.

5. The Member's coverage has been rescinded as described under the Rescission provision of this Contract.
6. The Member changes from one Exchange Certified Dental Plan to another during an annual open enrollment period or special enrollment period.
7. Election by The Plan to:
   a. Cease offering a particular type of coverage in the individual market; or
   b. Cease offering all coverage in the individual market.

Termination of Contract by the Member

The Beneficiary Member may cancel this Contract by notifying Blue Cross and Blue Shield of Montana in writing. Notice of cancellation will terminate this Contract on the first of the Month following receipt of the Member's written notification to cancel.

DENTAL SERVICES

The Benefits of this section are subject to all the terms and conditions of this Contract. Benefits are available only for services and supplies that are determined by The Plan to be Dentally Necessary, unless otherwise specified. All Dental Services listed in this section are subject to the Exclusions and Limitations section of this Contract, which lists services, supplies, situations or related expenses that are not covered.

The Schedule of Benefits indicates what the Deductible, Coinsurance and Benefit Period Maximum will be for a Dental Service.

Dental Benefits include coverage for the following Dental Services as long as these services are rendered by a Dentist or a Physician. When the term "Dentist" is used in this Contract, it will mean Dentist or Physician**.**

Diagnostic Evaluations

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

D0120 Periodic oral evaluation - Limited to 1 every 6 Months
D0140 Limited oral evaluation - problem focused
D0150 Comprehensive oral evaluation - Limited to 1 every 6 Months
D0160 Detailed and extensive oral evaluation - problem focused, by report
D0180 Comprehensive periodontal evaluation
D9310 Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment)

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

Preventive Services

Preventive services are performed to prevent dental disease. Dental Services include:

D1110 Prophylaxis - Adult - Limited to 1 every 6 Months
D1120 Prophylaxis - Child - Limited to 1 every 6 Months
D1206 Topical fluoride varnish - 2 in 12 Months
D1208 Topical application of fluoride (excluding prophylaxis) - 2 in 12 Months

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Periodontal maintenance combined with prophylaxes treatments (see "Non-Surgical Periodontic Services") are limited to four in a 12-Month period following completion of active periodontal therapy.

Diagnostic Radiographs

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

D0210 Intraoral - complete series (including bitewings) 1 every 60 (sixty) Months

D0220 Intraoral - periapical first film
D0230 Intraoral - periapical - each additional film
D0240 Intraoral - occlusal film
D0270 Bitewing - single film Adult -1 set every calendar year / Children - 1 set every 6 Months
D0272 Bitewings - two films - Adult -1 set every calendar year / Children - 1 set every 6 Months
D0274 Bitewings - four films Adult -1 set every calendar year / Children - 1 set every 6 Months
D0277 Vertical bitewings - 7 to 8 films - Adult -1 set every calendar year / Children - 1 set every 6 Months
D0330 Panoramic film - 1 film every 60 (sixty) Months
D0340 Cephalometric x-ray
D0350 Oral / Facial Photographic Images
D0391 Interpretation of Diagnostic Image

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

Miscellaneous Preventive Services

Miscellaneous preventive services are other services performed to prevent dental disease and include:

D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 Months
D1352 Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 Months
D1510 Space maintainer - fixed - unilateral - Limited to children under age 19
D1516 Space maintainer - fixed - bilateral - Limited to children under age 19
D1520 Space maintainer - removable - unilateral - Limited to children under age 19
D1526 Space maintainer - removable - bilateral - Limited to children under age 19
D1551 Re-cementation of space maintainer - Limited to children under age 19

Benefits are not available for nutritional, tobacco and oral hygiene counseling.

Basic Restorative Services

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Dental Services include:

D2140 Amalgam - one surface, primary or permanent
D2150 Amalgam - two surfaces, primary or permanent
D2160 Amalgam - three surfaces, primary or permanent
D2161 Amalgam - four or more surfaces, primary or permanent
D2330 Resin-based composite - one surface, anterior
D2331 Resin-based composite - two surfaces, anterior
D2332 Resin-based composite - three surfaces, anterior
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)

Benefits will not be provided for restorations placed within 12 Months of the initial placement by the same Dentist.

Non-Surgical Extractions

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Non-Surgical Periodontal Services

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

D4341 Periodontal scaling and root planing-four or more teeth per quadrant - Limited to 1 every 24 Months
D4342 Periodontal scaling and root planing-one to three teeth, per quadrant - Limited to 1 every 24 Months
D4346 Scaling gingival inflammation - Limited to 1 every 6 Months combined with prophylaxis and periodontal maintenance

D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
D4910 Periodontal maintenance procedures – 4 in 12 Months combined with prophylaxis after completion of active periodontal therapy
D7921 Collect - Apply Autologous Product - Limited to 1 in 36 Months

Adjunctive Services

Adjunctive general services include:

D9110 Palliative treatment of dental pain - minor procedure
D9222 Deep sedation/general anesthesia - first 30 minutes
D9223 Deep sedation/general anesthesia - each additional 15 minutes
D9239 Intravenous conscious sedation/ analgesia - first 30 minutes
D9243 Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes
D9610 Therapeutic drug injection, by report

Endodontic Services

Endodontics is the treatment of dental disease of the tooth pulp and includes:

D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3355 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410 Apicoectomy/periradicular surgery - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3450 Root amputation - per root
D3920 Hemisection (including any root removal) - not including root canal therapy

Oral Surgery Services

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth - partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D4263 Bone replacement graft for ridge preservation - per site
D7971 Excision of pericoronal gingiva

Surgical Periodontal Services

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

D4210 Gingivectomy or gingivoplasty - four or more teeth - Limited to 1 every 36 Months
D4211 Gingivectomy or gingivoplasty - one to three teeth
D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 Months
D4240 Gingival flap procedure, four or more teeth - Limited to 1 every 36 Months
D4241 Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant - Limited to 1 every 36 Months
D4249 Clinical crown lengthening hard tissue
D4260 Osseous surgery (including flap entry and closure) four or more contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 Months
D4261 Osseous surgery (including flap entry and closure) one to three contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 Months
D4270 Pedicle soft tissue graft procedure
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) for the first tooth, implant, or edentulous tooth position in the graft.
D4277 Free soft tissue graft - 1st tooth
D4278 Free soft tissue graft - additional teeth
D9930 Treatment of complications (post-surgical) unusual circumstances, by report

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

Major Restorative Services

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

D0160 Detailed and extensive oral evaluation – problem focused, by report
D2510 Inlay - metallic - one surface - An alternate Benefit will be provided
D2520 Inlay - metallic - two surfaces - An alternate Benefit will be provided
D2530 Inlay - metallic - three surfaces - An alternate Benefit will be provided
D2542 Onlay - metallic - two surfaces - Limited to 1 per tooth every 60 Months
D2543 Onlay - metallic - three surfaces - Limited to 1 per tooth every 60 Months
D2544 Onlay - metallic - four or more surfaces - Limited to 1 per tooth every 60 Months
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 Months
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 Months
D2751 Crown - porcelain fused to predominately base metal - Limited to 1 per tooth every 60 Months
D2752 Crown - porcelain fused to noble metal - Limited to 1 per tooth every 60 Months

D2780 Crown - 3/4 cast high noble metal - Limited to 1 per tooth every 60 Months
D2781 Crown - 3/4 cast predominately base metal - Limited to 1 per tooth every 60 Months
D2783 Crown - 3/4 porcelain/ceramic - Limited to 1 per tooth every 60 Months
D2790 Crown - full cast high noble metal - Limited to 1 per tooth every 60 Months
D2791 Crown - full cast predominately base metal - Limited to 1 per tooth every 60 Months
D2792 Crown - full cast noble metal - Limited to 1 per tooth every 60 Months
D2794 Crown - titanium - Limited to 1 per tooth every 60 Months
D2952 Post and core - Limited to 1 per tooth every 60 Months
D2940 Protective Restoration
D2981 Inlay Repair
D2982 Onlay Repair
D2983 Veneer Repair
D2990 Resin infiltration/smooth surface - Limited to 1 in 36 Months

Benefits will not be provided for the replacement of a lost, missing or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

Benefits will not be provided for services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

Benefits will not be provided for services to restore occlusion on incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 Months whether placement was provided under this Contract or under any prior dental coverage, even if the original crown was stainless steel.

Prosthodontic Services

Prosthodontics involve procedures necessary for providing artificial replacements for missing natural teeth and includes:

D5410 Adjust complete denture - maxillary
D5411 Adjust complete denture - mandibular
D5421 Adjust partial denture - maxillary
D5422 Adjust partial denture - mandibular
D5511 Repair broken complete denture base
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5611 D5612 Repair resin denture base
D5621 D5622 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
D5730 Reline complete maxillary denture - Limited to 1 in a 36-Month period 6 Months after initial installation
D5731 Reline complete mandibular denture - Limited to 1 in a 36-Month period 6 Months after initial installation
D5740 Reline maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
D5741 Reline mandibular partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-Month period 6 Months after initial installation
D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-Month period 6 Months after initial installation
D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in some 36-Month period 6 Months after initial installation
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-Month period 6 Months after initial installation
D5110 Complete denture - maxillary - Limited to 1 every 60 Months

D5120 Complete denture - mandibular - Limited to 1 every 60 Months
D5130 Immediate denture - maxillary - Limited to 1 every 60 Months
D5140 Immediate denture - mandibular - Limited to 1 every 60 Months
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months
D5213 Maxillary partial denture - cast mental framework with resin denture base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months
D5214 Mandibular partial denture - cast mental framework with resin denture base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months
D5282 Removable unilateral partial denture-one piece cast mental (including clast and teeth) - Limited to 1 every 60 Months

An implant is a covered procedure only if determined to be a Dental Necessity. Claim review is conducted by The Plan which reviews the clinical documentation submitted by the treating Dentist. If The Plan determines an arch can be restored with a standard prosthesis or restoration, no Benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate Benefit provision of The Plan (see “Alternate Care”).

D6010 Endosteal Implant - 1 every 60 Months
D6012 Surgical Placement if Interim Body - 1 every 60 Months
D6040 Eposteal Implant - 1 every 60 Months
D6050 Transosteal Implant, including hardware - 1 every 60 Months
D6110 D6111 Implant supported complete denture
D6112 D6113 Implant supported partial denture
D6055 Connecting Bar - implant or abutment supported - 1 every 60 Months
D6056 Prefabricated Abutment - 1 every 60 Months
D6057 Custom Abutment - 1 every 60 Months
D6058 Abutment supported porcelain ceramic crown - 1 every 60 Months.
D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 Months
D6060 Abutment supported porcelain fused to predominately base metal crowns
D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 Months
D6062 Abutment supported cast high noble metal crown - 1 every 60 Months
D6063 Abutment supported cast predominately base metal crown - 1 every 60 Months
D6064 Abutment supported cast noble metal crown - 1 every 60 Months
D6065 Implant supported porcelain/ceramic crown - 1 every 60 Months
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 Months
D6067 Implant supported metal crown - 1 every 60 Months
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 Months
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 Months
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 Months
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 Months
D6072 Abutment supported retainer for cast high noble metal fixed partial denture - 1 every 60 Months
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 Months
D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 Months
D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 Months
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 Months
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 Months
D6114 D6115 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 Months
D6116 D6117 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 Months
D6180 Implant Maintenance Procedures - 1 every 60 Months
D6081 Scaling and debridement implant – 1 every 60 Months
D6090 Repair Implant Prosthesis - 1 every 60 Months
D6091 Replacement of Semi-Precision or Precision Attachment - 1 every 60 Months
D6095 Repair Implant Abutment - 1 every 60 Months

D6100 Implant Removal - 1 every 60 Months
D6101 Debridement periimplant defect, covered if implants are covered - Limited to 1 every 60 Months
D6102 Debridement and osseous periimplant defect, covered if implants are covered - Limited to 1 every 60 Months
D6103 Bone graft implant periimplant defect, covered if implants are covered
D6104 Bone graft implant replacement, covered if implants are covered
D6190 Implant Index - 1 every 60 Months
D6210 Pontic - cast high noble metal - Limited to 1 every 60 Months
D6211 Pontic - cast predominately base metal - Limited to 1 every 60 Months
D6212 Pontic - cast noble metal - Limited to 1 every 60 Months
D6214 Pontic - titanium - Limited to 1 every 60 Months
D6240 Pontic - porcelain fused to high noble metal - Limited to 1 every 60 Months
D6241 Pontic - porcelain fused to predominately base metal - Limited to 1 every 60 Months
D6242 Pontic - porcelain fused to noble metal - Limited to 1 every 60 Months
D6245 Pontic - porcelain/ceramic - Limited to 1 every 60 Months
D6600 D6601 D6608 D6609 Inlay/onlay - porcelain/ceramic - Limited to 1 every 60 Months
D6602 D6604 D6606 Inlay - metallic - two surfaces - Limited to 1 every 60 Months
D6603 D6605 D6607 Inlay - metallic - three or more surfaces - Limited to 1 every 60 Months
D6611 D6613 D6615 Onlay - metallic - three surfaces - 1 every 60 Months
D6611 D6613 D6615 Onlay - metallic - four or more surfaces - 1 every 60 Months
D6545 Retainer - cast metal for resin bonded fixed prosthesis - 1 every 60 Months
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - 1 every 60 Months
D6549 Resin retainer – for resin bonded fixed prosthesis - 1 every 60 Months
D6740 Crown - porcelain/ceramic - 1 every 60 Months
D6750 Crown - porcelain fused to high noble metal - 1 every 60 Months
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 Months
D6752 Crown - porcelain fused to noble metal - 1 every 60 Months
D6780 Crown - 3/4 cast high noble metal - 1 every 60 Months
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 Months
D6782 Crown - 3/4 cast noble metal - 1 every 60 Months
D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 Months
D6790 Crown - full cast high noble metal - 1 every 60 Months
D6791 Crown - full cast predominately base metal - 1 every 60 Months
D6792 Crown - full cast noble metal - 1 every 60 Months
D9944 D9945 D9946 Occlusal guard, by report – 1 in 12 Months for patients 13 and older
D9942 Repair/reline occlusal guard – 1 every 24 Months for patients 13 and older
D9943 Occlusal guard adjustment – 1 every 24 Months for patients 13 and older

Note: Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

Note: Implant retained crowns, bridges, and dentures are subject to the alternate Benefit provision of The Plan (see “Alternate Care”).

1. Endosteal, eposteal, and transosteal implants – one every 60 Months only if determined to be a Dental Necessity.

Benefits will not be provided for the following Prosthodontic Services:

1. Treatment to replace teeth which were missing prior to the Effective Date.
2. Congenitally missing teeth.
3. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

D0470 Diagnostic Models
D2910 Re-cement inlay
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920 Re-cement crown

D2929 Prefabricated porcelain crown - primary - Limited to 1 every 60 Months
D2930 Prefabricated stainless steel crown - primary tooth - Under age 15 - Limited to 1 per tooth in 60 Months
D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 Months
D2950 Core buildup, including any pins - Limited to 1 per tooth every 60 Months
D2951 Pin retention - per tooth, in addition to restoration
D2954 Prefabricated post and core, in addition to crown - Limited to 1 per tooth every 60 Months
D2980 Crown repair, by report
D6930 Re-cement fixed partial denture
D6980 Fixed partial denture repair, by report

Medically Necessary Orthodontic Services

Benefits for Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth. Coverage for orthodontic services is shown on the Schedule of Benefits. Covered services include:

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8010 Interceptive orthodontic treatment of the primary dentition
D8020 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit (as part of Contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)

Note: Benefits for codes D0330, D0340, D0350, and D0470 will be applied to the lifetime orthodontia maximum when performed as part of orthodontia treatment.

Special Provisions Regarding Orthodontic Services:

Pediatric Orthodontic Services – Coverage is limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria established by The Plan (e.g., severe, dysfunctional malocclusion).

Benefits for Medically Necessary orthodontic services are limited to Members who meet the Policy criteria related to a medical condition including but are not limited to:

1. Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
2. Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services.
3. Skeletal anomaly involving maxillary and/or mandibular structures.

Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

1. Orthodontic services are paid over the Course of Treatment, up to the maximum Benefit Period orthodontic Benefit. Benefits cease when the Member is no longer covered, whether or not the entire Benefit has been paid out.
2. Orthodontic treatment is started on the date the bands or appliances are inserted. Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the Benefit Period maximum for orthodontic services.
3. If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
4. If the Member’s coverage is terminated prior to the completion of the orthodontic treatment plan, the Member is responsible for the remaining balance of treatment costs.

5. Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Member is not covered.
6. Benefits are not available for replacement or repair of an orthodontic appliance.
7. For services in progress on the Effective Date, Benefits will be reduced based on the Benefits paid prior to this coverage beginning.

Telehealth

Dentally Necessary Telehealth services are covered when provided by a Covered Provider.

EXCLUSIONS AND LIMITATIONS

All Benefits provided under this Contract are subject to the Exclusions and Limitations in this section and as stated under the Benefit section.

Important Information About the Member's Dental Benefits

Dental Procedures Which Are Not Dentally Necessary

Please note that in order to provide dental care Benefits at a reasonable cost, this Contract provides Benefits only for those covered Dental Services and eligible dental treatment that are determined by The Plan to be Dentally Necessary.

No Benefits will be provided for procedures which are not Dentally Necessary. Dentally Necessary generally means that a specific procedure provided to the Member is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to the Member, as determined by The Plan.

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Dentally Necessary.

Care by More Than One Dentist

If the Member changes Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if the Member had stayed with the same Dentist until treatment was completed. There will be no duplication of Benefits.

Non-Compliance with Prescribed Care

Any additional treatment and resulting liability which is caused by the lack of a Member's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Member.

The Plan will not pay for:

1. Services and treatment not prescribed by or under the direct supervision of a Dentist, except in those states where dental hygienists are permitted to practice without supervision by a Dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
2. Services and treatment which are experimental or investigational;
3. Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a Benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This Exclusion applies whether or not you claim the Benefits or compensation;
4. Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
5. Services and treatment performed prior to your Effective Date of coverage;
6. Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
7. Services and treatment which are not Dentally Necessary, or which do not meet generally accepted standards of dental practice;
8. Services and treatment resulting from your failure to comply with professionally prescribed treatment;
9. Any charges for failure to keep a scheduled appointment;

10. Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
11. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
12. Any loss for which a contributing cause was the commission of a felony or serious illegal act, or an attempt to commit a felony or serious illegal act, for which the Member has been found guilty in a court of competent jurisdiction or to which the Member has plead guilty or no contest. This Exclusion does not apply to the extent the Member suffers a loss as a victim of domestic violence;
13. Office infection control charges;
14. Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
15. State or territorial taxes on Dental Services performed;
16. Those submitted by a Dentist, which is for the same services performed on the same date for the same Member by another Dentist;
17. Those provided free of charge by any governmental unit, except where this Exclusion is prohibited by law;
18. Those for which the Member would have no obligation to pay in the absence of this or any similar coverage;
19. Those which are for specialized procedures and techniques;
20. Those performed by a Dentist who is compensated by a facility for similar covered services performed for Members;
21. Duplicate, provisional and temporary devices, appliances, and services;
22. Plaque control programs, oral hygiene instruction, and dietary instructions;
23. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
24. Gold foil restorations;
25. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
26. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
27. Hospital costs or any additional fees that the Dentist or hospital charges for treatment at the hospital (Inpatient or Outpatient);
28. Charges by the provider for completing dental forms;
29. Adjustment of a denture or bridgework which is made within 6 Months after installation by the same Dentist who installed it;
30. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
31. Cone Beam Imaging and Cone Beam MRI procedures;
32. Sealants for teeth other than permanent molars;
33. Precision attachments, personalization, precious metal bases and other specialized techniques;
34. Replacement of dentures that have been lost, stolen or misplaced;
35. Orthodontic care for Dependent children age 19 and over;
36. Repair of damaged orthodontic appliances;
37. Replacement of lost or missing appliances;
38. Fabrication of athletic mouth guard;
39. Internal and external bleaching;
40. Nitrous oxide;
41. Oral sedation;
42. Topical medicament center;
43. Orthodontic care for a Member or Spouse covered under the Standard Plan Option;
44. Bone grafts when done in connection with extractions, apicoectomies or non-covered/non-eligible implants;

45. When two or more services are submitted, and the services are considered part of the same service to one another The Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by The Plan;
46. When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), The Plan will pay for the service that represents the final treatment as determined by The Plan;
47. Amounts which are in excess of the Allowable Fee, as determined by The Plan.

CLAIMS

Notice of Claim

1. If a Member obtains Benefits from a participating provider, the participating provider will submit claims to The Plan for the Member. If a Member obtains Benefits from a nonparticipating provider, the Member may be required to submit all claims to The Plan. All claims for services must be submitted no later than 12 Months after the date on which the services were received after the end of the Benefit Period in which Dental Services were provided. All claims must provide enough information about the services for The Plan to determine whether or not they are a Benefit. Submission of such information is required before payment will be made. In certain instances, The Plan may require that additional documents or information including, but not limited to, accident reports, medical records, and information about other insurance coverage, claims, payments and settlements, be submitted within the timeframe requested for the additional documentation before payment will be made.

   NOTE: The Member must submit all claims for Dental Services provided outside of the state of Montana.

2. Claims must be submitted to the address listed on the inside cover of this Contract.

REBATES AND PREMIUM ABATEMENTS AND COST SHARING

Rebate In the event federal or state law requires The Plan to rebate a portion of annual premiums (dues) paid, The Plan will directly provide any rebate owed Beneficiary Members or former Beneficiary Members to such persons in amounts as required by law.

Abatement The Plan may from time to time determine to abate (all or some of) the premium (dues) due under this Contract for particular period(s). Any abatement of premium (dues) by The Plan represents a determination by The Plan not to collect premium (dues) for the applicable period(s) and does not represent a reduction in the rates under this Contract. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.

The Plan makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each Beneficiary Member or former Beneficiary Member (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

Cost-Sharing The Plan reserves the right from time to time to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Contract.

GENERAL PROVISIONS

Term

The term of this Contract is shown on the Schedule of Benefits. This Contract may be renewed as The Plan consents at dues set by The Plan.

Entire Contract; Changes

This Contract, including written riders, endorsements and attached papers, if any, constitutes the entire Contract between Blue Cross and Blue Shield of Montana and the Beneficiary Member. No change to this Contract is valid until made pursuant to the section entitled Modification of Contract.

Modification of Contract

The Plan may make administrative changes or changes in dues, terms or Benefits in this Contract by giving written notice to the Beneficiary Member at least 45 days before the Effective Date of the changes. Dues may not be increased more than once during a 12-Month period, except as allowed by Montana law.

No other agent or representative or employee of The Plan may change any part of this Contract. No change in the Contract will be valid unless in writing and signed by the President of Blue Cross and Blue Shield of Montana.

Clerical Errors

No clerical error on the part of The Plan shall operate to defeat any of the rights, privileges, or Benefits of any Member covered under this Contract. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of the Contract in strict accordance with its terms.

Conformity with Montana Statutes

The provisions of this Contract conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the Member resides on or after the Effective Date of this Contract.

Claim Forms

The Plan, upon receipt of a notice of claim, will furnish to the Member, such forms of proof of loss for completion by the Member. If the forms are not furnished within 15 days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Contract as to proof of loss upon submitting, within the time fixed in the Contract for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proofs of Loss

Written proof of loss must be furnished to The Plan at its said office in case of claim for loss for which this Contract provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which The Plan is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

Time of Payment of Claims

The Plan will pay or deny a claim within 30 days after receipt of a proof of loss unless The Plan makes a reasonable request for additional information or documents in order to evaluate the claim. If The Plan makes a reasonable request for additional information or documents, The Plan shall pay or deny the claim within 60 days of receiving the proof of loss unless The Plan has notified the Member, the Member's authorized representative, or the claimant of the reasons for failure to pay the claim in full or unless The Plan has a reasonable belief that insurance fraud has been committed and The Plan has reported the possible insurance fraud to the Commissioner of Insurance. This section does not eliminate a Plan's right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

If The Plan fails to comply with this section and The Plan is liable for payment of the claim, The Plan shall pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after The Plan's receipt of the Proof of Loss or 60 days after receipt of the Proof of Loss if The Plan made a reasonable request for

information or documents. Interest payments must be made to the person who receives the claims payment. Interest is payable under this subsection only if the amount of interest due on a claim exceeds $5.

Notices Under Contract

Any notice required by this Contract may be given by United States mail, postage paid. Notice to the Beneficiary Member will be mailed to the address appearing on the records of The Plan. Notice to The Plan must be sent to Blue Cross and Blue Shield of Montana at the address listed on the inside cover of this Contract. Any time periods included in a notice shall be measured from the date the notice was mailed.

A Beneficiary Member or Family Member may reasonably request, in writing, that any communication of the Member's health information be sent to an alternate address or by alternative means should disclosure of any of the Member's health information endanger the Member.

Notice of Annual Meeting

The Policyholder is hereby notified that the Policyholder is a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by proxy, at all meetings of Members of Blue Cross and Blue Shield. The annual meeting is held at our principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term “Member” as used above refers only to the person to whom this Contract has been issued. Under Family Coverage, the term “Member” does not include any person other than the Policyholder unless such person is acting upon the Policyholder’s behalf.

Rescission of Contract

This Contract is subject to rescission if the Member commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Member’s health, claims history, or current receipt of health care services. Blue Cross and Blue Shield of Montana will provide at least 30 days advance written notice to the subscriber before coverage may be rescinded.

Contract Not Transferable by the Member

No person, other than the Beneficiary Member or a Family Member listed on the subscriber application for membership and accepted by The Plan, is entitled to Benefits under this Contract. This Contract is not transferable to any other person.

Validity of Contract

If any part, term, or provision of this Contract is held by the courts to be illegal or in conflict with or not in compliance with any applicable law of the state of Montana or the United States, this Contract shall not be rendered invalid but shall be construed and applied in accordance with such provisions as would have applied had this Contract been in conformance with applicable law and the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if this Contract did not contain the particular part, term, or provision held to be invalid.

Execution of Papers

The Member agrees to execute and deliver any documents requested by The Plan which are necessary to administer the terms of this Contract.

Members Rights

Members have only those rights as specifically provided in this Contract. When requested by the Member or the Member’s agent, Blue Cross and Blue Shield of Montana is required to provide a summary of a Member’s coverage for a specific Dental Service when an actual charge or estimate of charges by a Dental Provider exceeds $500.

Alternate Care

In all cases in which there is more than one service or Course of Treatment to treat the Member's dental condition, the Benefit will be based on the less costly covered services or Course of Treatment.

When two or more services are submitted and the services are considered part of the same service, The Plan will pay the most comprehensive service as determined by The Plan.

When two or more services are submitted on the same day and the services are considered mutually exclusive (one service contradicts the need for the other service), The Plan will pay for the service that represents the final treatment as determined by The Plan.

If the Member and the Member's Dentist decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for Dental Services rather than standard procedures, the Benefits provided will be limited to the Benefit for the least costly Course of Treatment or procedures for Dental Services, as determined by The Plan.

Benefit Maximums

Once The Plan pays the maximum amount for a specific Benefit, no further payment will be made for that specific condition under any other provisions of this Contract.

Legal Actions

No action at law or in equity shall be brought to recover on this Contract prior to the expiration of 60 days after written Proof of Loss has been furnished in accordance with the requirements of this Contract. No such action shall be brought after the expiration of three years after the written Proof of Loss is required to be furnished.

Physical Examinations

Blue Cross and Blue Shield of Montana, at its own expense, shall have the right and opportunity to examine the person of a Member when and as often as it may reasonably require during the pending of a claim.

Fees

The Plan reserves the right to charge the Member a reasonable fee for providing information or documents to the Member which were previously provided in writing to the Member. Fees may be charged for the costs of copying labor, supplies and postage. Fees will not be charged for searching for and retrieving the requested information.

Time Limit on Certain Defenses

After two years from the date of issue of this Contract, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Contract shall be used to void the Contract or to deny a claim for loss incurred commencing after the expiration of such two-year period.

Acceptance of this Contract

When The Plan approves the Member's application and the Member pays the first Month's dues, this Contract is accepted by both parties.

Previous Contract Superseded

This Contract voids any previous Contract between The Plan and the Member.

Subrogation

1. To the extent that Benefits have been provided or paid under this Contract, The Plan may be entitled to subrogation against a judgment or recovery received by a Member from a third party found liable for a wrongful act or omission that caused the injury requiring payment for Benefits.
2. The Member will take no action through settlement or otherwise which prejudices the rights and interest of The Plan under this Contract.

3. If the Member intends to institute an action for damages against a third party, the Member will give The Plan reasonable notice of intention to institute the action. Reasonable notice will include information reasonably calculated to inform The Plan of facts giving rise to the third-party action.
4. The Member may request that The Plan pay a proportional share of the reasonable costs of the third-party action, including attorney fees. If The Plan elects not to participate in the cost of the action, The Plan waives 50 percent of its subrogation interest.
5. The right of subrogation may not be enforced until the Member has been completely compensated for the injuries.

When the Member Moves Out of State

If the Member moves to an area served by another Blue Cross or Blue Shield plan, the Member's coverage will be transferred to the plan serving the new address. The new plan must offer coverage that is in compliance with the conversion laws of that state. This coverage is that which is normally provided to Members who leave a group and apply for new coverage as individuals. Although subject to the conversion laws of that state, such coverage is usually provided without a medical examination or health statement. If the Member accepts the conversion coverage, the new plan will credit the Member for the length of time of enrollment with Blue Cross and Blue Shield of Montana toward any of its own waiting periods. Any physical or mental conditions covered by The Plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage. The premium rate and benefits available from the new plan may vary significantly from those offered by The Plan.

The new plan may also offer other types of coverage that are outside of the transfer program. This coverage may require a medical examination or health statement to exclude coverage for preexisting conditions and may not apply time enrolled in Blue Cross and Blue Shield of Montana to waiting periods.

Independent Relationship

Participating providers furnishing care to a Member do so as independent contractors with The Plan; however, the choice of a provider is solely the Member's. Under the laws of Montana, The Plan cannot be licensed to practice medicine or surgery and The Plan does not assume to do so. The relationship between a provider and a patient is personal, private, and confidential. The Plan is not responsible for the negligence, wrongful acts, or omissions of any providers, or provider's employees providing services, or Member receiving services. The Plan is not liable for services or facilities which are not available to a Member for any reason.

Blue Cross and Blue Shield of Montana as an Independent Plan

The Member hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between The Plan, that The Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting The Plan to use the Blue Cross and Blue Shield Service Mark in the state of Montana, and that The Plan is not contracting as the agent of the Association. The Member further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than The Plan and that no person, entity, or organization other than The Plan shall be held accountable or liable to the Member for any of Blue Cross and Blue Shield of Montana's obligations to the Member created under this Contract. 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 Contract.

DEFINITIONS

This section defines certain words used throughout this Contract. These words are capitalized whenever they are used as defined.

ALLOWABLE FEE

The amount determined by The Plan as the maximum amount eligible for payment of Benefits. A participating Dentist agrees to accept payment of the Allowable Fee from The Plan for covered Dental Services, together with any Deductible, Coinsurance and/or Copayment for the Member, as payment in full. Nonparticipating Dentists do

not have to accept The Plan's payment as payment in full and can bill the Member for the difference between payment by The Plan and provide charges plus Deductible, Coinsurance and/or Copayment. The Member will be responsible for the balance of the nonparticipating Dentist's charges after payment by The Plan and payment of any Deductible, Coinsurance and/or Copayment.

APPEAL

Request for review of a denied or partially denied claim and/or services.

BENEFICIARY MEMBER

A person who has applied for, been accepted as a Member, and maintains membership in The Plan under the terms of this Contract.

BENEFIT

Services, supplies and medications that are provided to a Member and covered under this Contract as a covered Dental Service.

BENEFIT PERIOD

For the Contract - Is the period of time shown in the Schedule of Benefits.

For the Member - Is the same as for the Contract except if the Member's Effective Date is after the Effective Date of the Contract, the Benefit Period begins on the Member's Effective Date and ends on the same date the Contract Benefit Period ends. Thus, the Member's Benefit Period may be less than 12 Months.

COINSURANCE

The percentage of the Allowable Fee payable by the Member for covered Dental Services. The applicable Coinsurance for In-Network covered Dental Services and Out-of-Network covered Dental Services is stated in the Schedule of Benefits.

COMPLAINT

Any communication from the Member or on the Member's behalf which expresses:

1. Dissatisfaction;
2. Disagreement;
3. Lack of action; or
4. Threats.

CONTRACT

This Contract, the Member's application and any amendments, endorsements, riders, or modifications made to it by The Plan.

COURSE OF TREATMENT

Any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERED PROVIDER

A participating or nonparticipating provider which has been recognized by Blue Cross and Blue Shield of Montana as a provider of services for Benefits described in this Contract. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, The Plan looks to the nature of the services rendered, the extent of licensure and The Plan's recognition of the provider.

DEDUCTIBLE

The dollar amount each Member must pay for Dental Services incurred during the Benefit Period before The Plan will make payment for any Dental Services to which the Deductible applies. Only the Allowable Fee for Dental Services is applied to the Deductible. Thus, Member responsibility for Coinsurance, noncovered services, or amounts billed by nonparticipating providers, does not apply to the Deductible.

If three or more Members covered under the same Family Membership satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Member of the Family Membership.

DENTAL PROVIDER

A Dental Provider may be participating or nonparticipating. A participating Dental Provider is a provider who has a contract with Blue Cross and Blue Shield of Montana. These providers agree to accept payment directly from Blue Cross and Blue Shield of Montana for covered dental Benefits. This payment, together with the Member's

Deductible and Coinsurance described in the Schedule of Benefits, is accepted as payment in full. The Member may obtain a list of participating Dental Providers from Blue Cross and Blue Shield of Montana upon request.

If a Member receives services from a nonparticipating Dental Provider, the Member is responsible for the balance of the nonparticipating provider's bill after payment by Blue Cross and Blue Shield of Montana.

DENTAL SERVICES

Dental Services for which allowances are provided in this Contract.

DENTALLY NECESSARY/DENTAL NECESSITY

Those services, supplies, or appliances covered under The Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. Not primarily for the convenience of the Member or his Dentist; and
4. The most economical supplies, appliances, or levels of Dental Service that are appropriate for the safe and effective treatment of the Member.

DENTIST/PHYSICIAN

A person licensed to practice dentistry in the state where the service is provided.

DENTURIST

A person licensed as a Denturist in the state where the service is provided.

DEPENDENT

1. The Beneficiary Member's Spouse;
2. The Beneficiary Member's unmarried or married child up to age 26, including an eligible foster child;
3. Children for whom the Beneficiary Member becomes legally responsible by reason of placement for adoption, as defined in Montana law; or
4. An unmarried child of the Beneficiary Member who is 26 years of age or older and disabled.

For purposes of this Contract the unmarried child will be considered disabled if the child:

1. Was covered under this Contract before age 26;
2. Cannot support himself/herself because of intellectual disability or physical disability; and
3. Is legally dependent on the Beneficiary Member for support.

Proof of those qualifications must be supplied to The Plan within 31 days following the child's 26th birthday. Although there is no limiting age for disabled children, The Plan reserves the right to require periodic certification from the Beneficiary Member of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

EFFECTIVE DATE

For a Member - the Effective Date of a Member's coverage means the date the Member:

1. Has met the requirements of The Plan stated in this Contract; and
2. Is shown on the records of The Plan to be eligible to receive Benefits.

For the Contract - the Effective Date of the Contract is the date shown on the face of this Contract.

For any endorsement, rider, or amendment - the Effective Date is the date shown on the Contract unless otherwise shown on the endorsement, rider and amendment.

EXCHANGE

A governmental agency or nonprofit entity that meets the applicable standards and makes Qualified Health Plans (QHPs) available to Qualified Employees and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchange, subsidiary Exchange, and a Federally facilitated Exchange.

EXCHANGE CERTIFIED DENTAL PLAN

A dental plan that has in effect a certification that it meets the applicable standards issued or recognized by each Exchange through which such plan is offered.

EXCLUSION
A provision which states that The Plan has no obligation under this Contract to make payment.

FAMILY MEMBER
A Dependent who has been accepted as a Member of The Plan and enrolled by a Beneficiary Member.

FAMILY MEMBERSHIP
The family unit including the Beneficiary Member and all Family Members who have been accepted as Members of The Plan.

GRIEVANCE
A Complaint about the quality of care, or services rendered by a provider or provider officer.

INCLUSIVE SERVICES/PROCEDURES
A portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) (FOR MEDICALLY NECESSARY PEDIATRIC ORTHODONTIA)
Health care services that a Covered Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient or health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Member receives the services, supplies, or medications and a claim is submitted to The Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MEMBER
Both the Beneficiary Member and Family Members.

MONTH
For the purposes of this Contract, a Month has 30 days even if the actual calendar Month is longer or shorter.

MONTHLY DUES
The amount of money which must be paid monthly by the Beneficiary Member to keep this Contract in force.

PLAN - THE PLAN
Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

POLICYHOLDER
The individual who has applied for and been accepted for coverage and to whom the Contract has been issued.

SPOUSE
The opposite sex or the same sex person to whom the Beneficiary Member is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

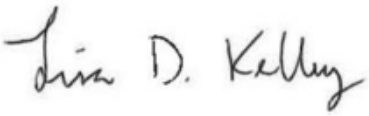
TELEHEALTH

The use of audio, video, or another telecommunications technology or media, including audio-only communication that is:

1. Used by a health care provider or health care facility to deliver health care services; and
2. Delivered over a secure connection that complies with state and federal laws.

Telehealth does not include delivery of Dental Services by means of facsimile machine or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

BLUE CROSS BLUE SHIELD OF MONTANA
A DIVISION OF HEALTH CARE SERVICE CORPORATION
A MUTUAL LEGAL RESERVE COMPANY



By: Lisa Kelley
President, Blue Cross and Blue Shield of Montana

BlueCross BlueShield of Montana

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbsmt.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

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BlueCross BlueShield of Montana

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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