

Summary of Benefits

Family Dental PPO

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

This Plan has separate Benefits for Pediatric Members and Adult Members. Pediatric Benefits are available for Members through the end of the month in which the Member turns 19. Adult Benefits are available for Members 19 and older.

Dental Provider Network:

DPPO Network

This Plan uses a specific network of dental care providers, called the DPPO provider network. Dentists in this network are called Participating Dentists. You pay less for Covered Services when you use a Participating Dentist than when you use a Non-Participating Dentist. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductible (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating Dentist ³	When using a Non-Participating Dentist ⁴
Calendar Year Pediatric Deductible	<i>Individual coverage</i>	\$75	\$75
	<i>Family coverage</i>	\$75: individual	\$75: individual
		\$150: Family	\$150: Family
Calendar Year Adult Deductible	<i>Individual coverage</i>	\$50	\$50
	<i>Family coverage</i>	Not applicable	Not applicable

Calendar Year Out-of-Pocket Maximum⁵

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

		When using a Participating Dentist ³	When using a Non-Participating Dentist ⁴
Calendar Year Pediatric Out-of-Pocket Maximum	<i>Individual coverage</i>	\$350	No maximum
	<i>Family Coverage</i>	\$350: individual	No maximum
		\$700: Family	No maximum
Calendar Year Adult Out-of-Pocket Maximum	<i>Individual coverage</i>	No maximum	No maximum
	<i>Family Coverage</i>	Not applicable	Not applicable

Calendar Year Benefit Maximum⁶

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

		When using a Participating ³ or Non-Participating ⁴ Dentist
Calendar Year Pediatric Benefit Maximum		No maximum
Calendar Year Adult Benefit Maximum	<i>Individual coverage</i>	\$1,500
	<i>Family coverage</i>	Not applicable

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services. The waiting period may be waived with proof of prior comparable coverage.

Pediatric waiting period	No waiting period
Adult waiting period	6 months for major services

No Lifetime Dollar Limit

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

Pediatric Benefits^{7,8,9}

Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>	When using a Participating Dentist ³	CYD ² applies	When using a Non-Participating Dentist ⁴	CYD ² applies
Office visit	\$0		\$0	
Diagnostic and preventive services				
Oral exam	\$0		10%	
Preventive – cleaning	\$0		10%	
Preventive – x-ray	\$0		10%	
Sealants per tooth	\$0		10%	
Topical fluoride application	\$0		10%	
Space maintainers – fixed	\$0		10%	
Basic services				
Restorative procedures	20%	✓	30%	✓
Periodontal maintenance	20%	✓	30%	✓
Adjunctive general services	20%	✓	30%	✓
Major services				
Oral Surgery	50%	✓	50%	✓
Endodontics	50%	✓	50%	✓
Periodontics (other than maintenance)	50%	✓	50%	✓
Crowns and casts	50%	✓	50%	✓
Prosthodontics	50%	✓	50%	✓
Orthodontics (Medically Necessary)	50%	✓	50%	✓

Adult Benefits^{7,8,9}

Your payment

<i>Adult Benefits are available for Members age 19 and older.</i>	When using a Participating Dentist³	CYD² applies	When using a Non-Participating Dentist⁴	CYD² applies
Office visit	\$0		\$0	
Diagnostic and preventive services				
Oral exam	\$0		10%	
Preventive – cleaning	\$0		10%	
Preventive – x-ray	\$0		10%	
Sealants per tooth	\$0		10%	
Topical fluoride application	\$0		10%	
Space maintainers – fixed	\$0		10%	
Basic services				
Restorative procedures	20%	✓	30%	✓
Periodontal maintenance	20%	✓	30%	✓
Adjunctive general services	20%	✓	30%	✓
Major services				
Oral Surgery	50%	✓	50%	✓
Endodontics	50%	✓	50%	✓
Periodontics (other than maintenance)	50%	✓	50%	✓
Crowns and casts	50%	✓	50%	✓
Prosthodontics	50%	✓	50%	✓
Orthodontics (Medically Necessary)	Not covered		Not covered	

Notes

1 Evidence of Coverage (EOC):

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

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

2 Calendar Year Deductible (CYD):

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

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✓) in the Benefits chart above.

Covered Services not subject to the Calendar Year Deductible. Some Covered Services are paid by Blue Shield before you meet any Calendar Year Deductible. These Covered Services do not have a check mark (✓) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has separate Deductibles for:

- Pediatric Deductible and Adult Deductible
- Participating Dentist Deductible and Non-Participating Dentist Deductible

Individual Pediatric Deductible. Each Pediatric Member is responsible for the individual Deductible unless the family Deductible has been met, if applicable.

Individual Adult Deductible. Each Adult Member is responsible for an individual Deductible.

Family Pediatric Deductible. Family coverage applies to two or more Pediatric Members only. In a plan with two or more Pediatric Members, cost sharing payments made by each Pediatric Member for in-network services contribute to both the individual in-network Deductible and the family in-network Deductible, if applicable. Cost sharing payments made by each Pediatric Member for out-of-network Covered Services contribute to both the individual out-of-network Deductible and the family out-of-network Deductible, if applicable.

Once the individual Deductible or the family Deductible (if applicable) is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

3 Using Participating Dentists:

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

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Dentists:

Non-Participating Dentists do not have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Non-Participating Dentist, you are responsible for both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount (which can be significant).

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards the Out-of-Pocket Maximum or any Benefit maximums, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. Once you reach the OOPM, the Plan will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

This Plan has separate Out-of-Pocket Maximums for:

- Pediatric OOPM and Adult OOPM
- Participating Dentist OOPM and Non-Participating Dentist OOPM

Individual Pediatric OOPM. Cost sharing payments made by each Pediatric Member for in-network Covered Services accrue to the individual OOPM.

Individual Adult OOPM. Cost sharing payments made by each Adult Member for in-network Covered Services accrue to the individual OOPM.

Notes

Family Pediatric OOPM. Family coverage applies to two or more Pediatric Members only. In a plan with two or more Pediatric Members, cost sharing payments made by each Pediatric Member for in-network services contribute to both the individual in-network OOPM and the family in-network OOPM.

Non-Participating Dentist OOPM. Cost sharing payments made by Members for out-of-network Covered Services do not accumulate to the OOPM.

6 Benefit Maximum(s):

Your payment after you reach any Benefit maximum. You will pay 100% of all charges after you reach a Benefit maximum.

All Covered Services count towards the Calendar Year Benefit maximum. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

7 Separate Member Payments When Multiple Covered Services are Received:

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

8 Dental Care Services:

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

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

Other Covered Services. Tooth whitening, Adult orthodontia, Implants, veneers, and Adult services noted as Not Covered on the Dental Schedule and Limitations Table in the EOC are not covered services.

This plan is compliant with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

9 Prior Authorization:

Prior Authorization or precertification for Covered Services. Before any course of treatment expected to cost more than \$250 is started, you should obtain prior authorization of Benefits, except in an emergency.

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

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

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

Fax: (844) 696-6070

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

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

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

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

Notice of the Availability of Language Assistance Services

Blue Shield of California

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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