blue of california

Summary of Benefits

COVERED CALIFORNIA

Individual and Family Dental Plan
DPPO Plan

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	*Individual coverage*	$75	$75
	Family coverage	$75: individual	$75: individual
		$150: Family	$150: Family
Calendar Year Adult Deductible	*Individual coverage*	$50	$50
	Family coverage	Not applicable	Not applicable

Calendar Year Out-of-Pocket Maximum[5]

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	*Individual coverage*	$350	No maximum
	Family Coverage	$350: individual	No maximum
		$700: Family	No maximum
Calendar Year Adult Out-of-Pocket Maximum	*Individual coverage*	No maximum	No maximum
	Family Coverage	Not applicable	Not applicable

Calendar Year Benefit Maximum[6]

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 PediatricBenefit Maximum		No maximum
Calendar Year Adult Benefit Maximum	*Individual coverage*	$1,500
	Family coverage	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]

Pediatric Benefits are available through the end of the month in which the Member turns 19.	**Your payment** 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			
Adult Benefits are available for Members age 19 and older.	**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)	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

Notes

- 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.

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.

Notes

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.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。