

**Gold DPPO/\$2000/U90/Adult+Child Ortho**

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)<sup>1</sup>. Please read both documents carefully for details.

**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](http://blueshieldca.com).

**Calendar Year Deductible (CYD)<sup>2</sup>**

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.

		<b>When using a Participating<sup>3</sup> or Non-Participating<sup>4</sup> Dentist</b>
<b>Calendar Year Deductible</b>	<i>Individual coverage</i>	\$50 per individual
	<i>Family coverage</i>	\$50: individual \$150: Family

**Calendar Year Benefit Maximum<sup>5</sup>**

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

	<b>When using any combination of Participating<sup>3</sup> and Non-Participating<sup>4</sup> Dentists</b>	<b>When Using a Non-Participating Dentist<sup>4</sup></b>
<b>Calendar Year Benefit Maximum</b>	\$2,000: individual	\$2,000: individual

**Lifetime Benefit Maximum (Orthodontic Services)<sup>5</sup>**

This maximum for covered Orthodontic services is the total amount that Blue Shield will pay for covered Orthodontic services in a Member's lifetime. Orthodontic Benefits are covered for adults and children.

	<b>When using any combination of Participating<sup>3</sup> and Non-Participating<sup>4</sup> Dentists</b>
<b>Lifetime Benefit Maximum (Orthodontic Services)</b>	\$2,000: individual

**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.

<b>Waiting period</b>	No waiting period
-----------------------	-------------------

**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 except for Orthodontic services listed above.

**Benefits<sup>6,7,8</sup>**

**Your payment**

	When using a Participating Dentist <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Dentist <sup>4</sup>	CYD <sup>2</sup> applies
<b>Diagnostic and preventive services</b>				
Oral exam	\$0		\$0	
Preventive – cleaning	\$0		\$0	
Preventive – x-ray	\$0		\$0	
Topical fluoride application	\$0		\$0	
Periodontal maintenance	\$0		\$0	
Enhanced dental benefits for pregnant women	\$0		\$0	
<b>Basic services</b>				
Sealants per tooth	10%	✓	20%	✓
Space maintainers – fixed	10%	✓	20%	✓
Restorative procedures	10%	✓	20%	✓
Endodontics	10%	✓	20%	✓
Periodontics (other than maintenance)	10%	✓	20%	✓
<b>Major services</b>				
Oral Surgery	40%	✓	50%	✓
Crowns and casts	40%	✓	50%	✓
Prosthodontics	40%	✓	50%	✓
Implants	40%	✓	50%	✓
<b>Orthodontics</b>				
	50%		50%	
<i>Orthodontic Benefits are covered for adults and children.</i>				

**Dental Smile Rollover Rewards<sup>9</sup>**

Initial Maximum Calendar Year Benefit	Annual Claim Threshold	Annual Account Reward	Annual Network Reward	Total Annual Reward	Total Reward Account Maximum	Potential Maximum Calendar Year Benefit (Initial Maximum Calendar Year Benefit + Total Reward Account Maximum)
\$2,000	\$500	\$250	\$100	\$350	\$1,000	\$3,000

**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.

## Notes

---

### 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.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Any amount you have paid toward the Deductible for your individual plan will be applied to both the individual Deductible and the Family Deductible for your new plan.

---

### 3 Using Participating Dentists:

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

"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 any Benefit maximums, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

The Non-Participating Dentist reimbursement amount is the usual, customary, and reasonable rate or UCR rate. The UCR rate is the cost for a typical service within a specified region and it may differ depending on where you receive services. When you receive services from a Non-Participating Dentist, you pay any amount above the UCR rate. The Allowable Amount is based off the 90<sup>th</sup> percentile of UCR.

---

### 5 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 except for Orthodontic services. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

This Plan has a combined Participating Dentist and Non-Participating Dentist Calendar Year Benefit maximum as well as a Non-Participating Dentist Benefit maximum. This means that any amount the Plan pays towards Covered Services for Non-Participating Dentists also counts towards the combined Participating and Non-Participating Dental Benefit maximum.

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

## Notes

---

Enhanced dental benefits for pregnant women do not apply towards the Calendar Year Benefit Maximum.

---

### **6 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.

---

### **7 Dental Care Services:**

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

*Orthodontic Covered Services.* The Copayment or Coinsurance for Orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies only if the Member remains enrolled in the Plan. All procedures performed in connection with Orthodontic treatment are payable as Orthodontic Covered Services. Benefits for the initial placement will not exceed 20% of the Lifetime Benefit Maximum for Orthodontic Covered Services. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the Orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the Orthodontic treatment, are all subject to the Orthodontics coinsurance level and lifetime Benefit maximum as defined above.

---

### **8 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.

---

### **9 Dental Smile Rewards Program:**

*With the Dental Smile Rollover Rewards Program, Blue Shield rewards you for getting diagnostic and preventive care from your Dentist during the year.* Your reward accumulates, will be carried over each year, and is available for use beginning in the next benefit period (see the Dental Smile Rollover Rewards section of the Evidence of Coverage for details on how the program works).

If the Member's Plan has different Participating and Non-Participating Initial Maximum Calendar Year Benefits, the Annual Account Reward amount will be determined by the Non-Participating Initial Maximum Calendar Year Benefit amount.

---

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](mailto: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](http://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'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodiłnih. (Navajo)

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

**ԿԱՐՆՎՈՐ Է.** Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: 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 الخفي 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 ntwam 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. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້. ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)