blue of california

COVERED CALIFORNIA

Summary of Benefits

Individual and Family Dental Plan
DHMO Plan

Family Dental HMO

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: DHMO Network

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

Calendar Year Deductible (CYD)[2]

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

		When using a Participating Dentist[3]
Calendar Year Pediatric Deductible	*Individual coverage*	$0
	Family coverage	$0
Calendar Year Adult Deductible	*Individual coverage*	$0
	Family coverage	Not applicable

Calendar Year Out-of-Pocket Maximum[4]

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

Blue Shield of California is an independent member of the Blue Shield Association

Calendar Year Benefit Maximum

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

		When using a Participating Dentist[3]
Calendar Year PediatricBenefit Maximum	*Individual coverage*	No maximum
	Family coverage	No maximum
Calendar Year Adult Benefit Maximum	*Individual coverage*	No maximum
	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.

Pediatric waiting period	No waiting period
Adult waiting period	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.

Pediatric Benefits[5,6]

Pediatric Benefits are available through the end of the month in which the Member turns 19.	**Your payment** **When using a Participating Dentist[3]**
Office visit	$0
Diagnostic and preventive services	
Oral exam	$0
Preventive – cleaning	$0
Preventive – x-ray	$0
Sealants per tooth	$0
Topical fluoride application	$0
Space maintainers – fixed	$0
Basic services	
Restorative procedures Periodontal maintenance Adjunctive general services	See Dental Copay Schedule in Evidence of Coverage
Major services	
Oral Surgery Endodontics Periodontics (other than maintenance) Crowns and casts Prosthodontics	See Dental Copay Schedule in Evidence of Coverage
Orthodontics (Medically Necessary)	$350

Adult Benefits[5,6]	Your payment
Adult Benefits are available for Members age 19 and older.	**When using a Participating Dentist[3]**
Office visit	$0
Diagnostic and preventive services	
Oral exam	$0
Preventive – cleaning	$0
Preventive – x-ray	$0
Sealants per tooth	$0
Topical fluoride application	$0
Space maintainers – fixed	$0
Basic services	
Restorative procedures	See Dental Copay Schedule in Evidence of Coverage
Periodontal maintenance	
Adjunctive general services	
Major services	
Oral Surgery	See Dental Copay Schedule in Evidence of Coverage
Endodontics	
Periodontics (other than maintenance)	
Crowns and casts	
Prosthodontics	
Orthodontics (Medically Necessary)	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.

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.

Notes

4 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.

5 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.

6 Dental Care Services:

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

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

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 as long as the Member remains enrolled in the Plan.

Teledentistry. To the extent this Plan offers teledentistry, it is offererd at no charge.

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.

Administration of these plan designs must comply 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.

These endnotes do not limit and issuer's obligations to comply with applicable federal, state, or local laws, rules or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these endnotes.

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)**。