Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Dental HMO Deluxe
Type of Product Line: DHMO
Effective Date: Beginning On or After 1/1/2023

Name of Product: A45758
Plan Phone #: 1-888-702-4171
Plan Website: blueshieldca.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE blueshieldca.com OR CALL 1-888-702-4171. THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	$0	Not applicable

- There is no deductible.
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	None	Not applicable
Lifetime Maximum for Orthodontia	None	Not applicable

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package has no waiting period.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	$0	Not covered	One in a 3-year period.
Bitewing X-ray	Preventive & Diagnostic	$0	Not covered	Two in a 6-month period.
Cleaning	Preventive & Diagnostic	$0	Not covered	For adults age 17 and older, two cleanings in a 12-month period covered in full as preventive. Additional cleanings within the 12-month period have a cost share of $45.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
				Enhanced dental benefit for pregnant women age 17 and older: one additional cleaning in a 12-month period is covered in full as preventive.
Filling	Basic	$0	Not covered	Once per tooth in a 12-month period.
Extraction, Erupted Tooth or Exposed Root	Basic	$6/tooth	Not covered	Once per tooth.
Root Canal	Basic	$145	Not covered	One per tooth per lifetime.
Scaling and Root Planing	Basic	$10	Not covered	Once per quadrant in a 24-month period; two quadrants per visit. Enhanced dental benefit for pregnant women aged 17 and older - one course (up to 4 quadrants) of periodontal scaling and root planing for women during pregnancy with a documented existing periodontal condition is covered in full as preventive.
Ceramic Crown	Major	$125/crown	Not covered	One per tooth in a 5-year period.
Removable Partial Denture	Major	$175/denture	Not covered	One in a 5-year period.
Extraction, Erupted Tooth with Bone Removal	Basic	$15	Not covered	Once per tooth.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Orthodontia	Orthodontia	D8070: $1,200 D8080: $1,200 D8090: $1,500 D8210: $360 D8220: $406 D8660: $250 D8670: $0 D8680: $250/retainer D8696: $88 D8697: $88	Not covered	One continuous course of treatment in a 24-month period.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: $400 Out-of-network: $550	Total Cost of Care	In-network: $150 Out-of-network: $200	Total Cost of Care	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: $0 Out-of-network: Not applicable	Deductible	In-network: $0 Out-of-network: Not applicable	Deductible	In-network: $0 Out-of-network: Not applicable

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: $61 Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $125 Out-of-network: $1,750
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: $0 Out-of-network: $550**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $61 Out-of-network: $200**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $125 Out-of-network: $1,750**
Summary of what is not covered or subject to a limitation:	**Exam:** One in a 3-year period. **X-rays (FMX):** Two in a 6-month period. **Cleaning:** Two in a 12-month period.	Summary of what is not covered or subject to a limitation:	Once per tooth in a 12-month period.	Summary of what is not covered or subject to a limitation:	One per tooth in a 5-year period.

Blue Shield of California

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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.**

Blue Shield of California
601 12th Street, Oakland CA 94607

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Language Access Services

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

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Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwijį' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

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Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ)៖ សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

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