Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Smile℠ Spectrum Premier Plus 50/1500/Ortho/U90
Type of Product Line: DPPO
Effective Date: Beginning On or After 1/1/2023
Name of Product: A20058
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	$50 per individual $150 per family	$50 per individual $150 per family

- The deductible applies to all services except for diagnostic and preventive services, enhanced dental benefits for pregnant women and orthodontic services. Any amount you pay for in-network or out-of-network services will apply to both the in-network and out-of-network calendar year deductibles.
- 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	All services except orthodontia: $1,500 Orthodontia: $1,000	Yes, the cost-sharing will be higher. Contact your Plan.
Lifetime Maximum for Orthodontia	No	No

- **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	$0	One in a 3-year period.
Bitewing X-ray	Preventive & Diagnostic	$0	$0	Two in a 6-month period.
Cleaning	Preventive & Diagnostic	$0	$0	Two in a 12-month period.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
				Enhanced dental benefit for pregnant women aged 17 and older - one additional cleaning in a 12-month period is covered in full as preventive.
Filling	Basic	10%	20%	Once per tooth in a 12-month period.
Extraction, Erupted Tooth or Exposed Root	Basic	10%	20%	Once per tooth.
Root Canal	Basic	10%	20%	One per tooth per lifetime.
Scaling and Root Planing	Basic	10%	20%	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	40%	50%	One per tooth in a 5-year period.
Removable Partial Denture	Major	40%	50%	One in a 5-year period.
Extraction, Erupted Tooth with Bone Removal	Basic	10%	20%	Once per tooth.
Orthodontia	Orthodontia	50%	50%	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: $50 Out-of-network: $50	Deductible	In-network: $50 Out-of-network: $50	Deductible	In-network: $50 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan.	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan.	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan.
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: $0	Patient Cost (copayment or coinsurance)	In-network: 10% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 40% Out-of-network: 50%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: $0 Out-of-network: $0**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $65 Out-of-network: $90**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $570 Out-of-network: $925**

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Summary of what is not covered or subject to a limitation:	**Exam:** One in a 3-year period. **X-ray:** 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.**

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Language Access Services

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

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

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

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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।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

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