blue of california

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Dental HMO Elite 75
Type of Product Line: DHMO
Effective Date: Beginning On or After 1/1/26
Name of Product: A52478
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	None	Not applicable
Orthodontia	None	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	No maximum	Not applicable
Lifetime or Annual Maximum for Orthodontia	No maximum	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	Comprehensive oral exams listed here are limited to one in a 3-year period. Periodic oral exams have a separate cost share and limitation. Please see the *Summary of Benefits* for information.
Bitewing X-ray	Preventive & Diagnostic	$0	Not covered	Bitewing radiograph - single film - Two sets of single films or one set of two films every 6 months.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Cleaning	Preventive & Diagnostic	$0	Not covered	Prophylaxis - adult - For adults, 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. Enhanced dental benefit for pregnant women: one additional cleaning in a 12-month period is covered in full as preventive. Services are only covered by your primary care provider.
Filling	Basic	$0	Not covered	Resin-based composite - one surface, anterior - Once per tooth in a 12-month period.
Extraction, Erupted Tooth or Exposed Root	Basic	$0	Not covered	Extraction - erupted tooth or exposed root, including elevation and/or forceps removal - Once per tooth.
Root Canal	Basic	$150	Not covered	Endodontic therapy - molar tooth (excluding final restoration) - One per tooth, per lifetime.
Scaling and Root Planing	Basic	$20	Not covered	Periodontal scaling and root planing - four or more teeth - per quadrant - Once per quadrant in a 24-month period; two quadrants per visit. Enhanced dental benefit for pregnant women - 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	$225/crown	Not covered	Crown - porcelain/ceramic - One per tooth in a 5-year period.
Removable Partial Denture	Major	$125/denture	Not covered	Maxillary partial denture - cast metal framework with resin denture bases, including retentive/clasping materials, rests, and teeth - One in a 5-year period.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Extraction, Erupted Tooth with Bone Removal	Basic	$0	Not covered	Extraction - erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated - Once per tooth.
Orthodontia	Orthodontia	D8020: $1,000 D8030: $1,000 D8040: $1,000 D8050: $1,150 D8060: $1,150 D8070: $1,775 D8080: $1,775 D8090: $1,975 D8660: $0 D8670: $0 D8680: $125/retainer D8681: $0 D8695: $25 D8999: See SOB	Not covered	One course of treatment per lifetime. The course of treatment must be received in a 24 consecutive month period. Costs listed are per service.

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 (full mouth x-ray) 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
Annual Maximum (Plan Will Pay)	In-network: No maximum Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: No maximum Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: No maximum Out-of-network: Not applicable
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: $65 Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $225 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: $65 Out-of-network: $200**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $225 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 (full-mouth x-ray):** Two sets of single films or one set of two films every 6 months. **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.

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)**.

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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)**。