

**Smile<sup>SM</sup> Dental In-Network Only (DINO) 50/1500/No 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 must receive services from a Participating Dentist, but there are some exceptions. 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.

		<b>When using a Participating Dentist<sup>3</sup></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>4</sup>**

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

		<b>When using a Participating Dentist<sup>3</sup></b>
<b>Calendar Year Benefit Maximum</b>		\$1,500: 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
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**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.

**Benefits<sup>5,6,7</sup>**

**Your payment**

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

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

## Notes

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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.

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### 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. All Covered Services must be provided by Participating Dentists. No Benefits are provided when you receive services from a Non-Participating Dentist, except for Medically Necessary Covered Services received for emergency care.

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### 4 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. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

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

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### 5 Dental Care Services:

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

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### 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.

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### 7 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.

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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](https://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](https://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](https://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)**。