

Blue Shield Dental PPO

Smile Basic

75/1000/No Ortho/MAC

Finding a network dentist

It's easy to choose a dentist. With a broad network of PPO dentists to pick from, you should be able to find one near you. The dental PPO directory is available online in the *Find a Provider* section at blueshieldca.com, or by calling Customer Service at **(888) 702-4171**. When you receive care from a network dentist, you pay only the applicable deductibles and copayments, and there are no claim forms to file.

Using a dentist that's not in the network

Select any licensed dentist. If you use a dentist that's not in the network, your total out-of-pocket expenses may be higher. You pay at the time of service and afterwards you can file a claim with Blue Shield to receive reimbursement of covered service or you can choose to have the reimbursement sent to your non-network dentist.

Your cost for services

- You pay a \$75 deductible (\$225/family) each calendar year for services other than diagnostic and preventive services at a network or non-network dentist.
- When diagnostic and preventive services are provided by a network dentist, you're covered at 100 percent. At a non-network dentist, you're covered at 50 percent.
- After the deductible is met, Blue Shield pays a set percentage of the charges up to the maximum amount depending on the service received.
- Blue Shield will pay up to \$1,000 for dental services from network dentists during the calendar year (or up to \$750 when using a non-network dentist). Charges for services above the maximum are your responsibility.
- Any amount above covered benefits.

Summary of benefits

Dental PPO Smile SM Basic 75/1000/No Ortho/MAC Plan	Blue Shield pays	
	Network dentist	Non-network dentist
Diagnostic and preventive care (not subject to plan deductibles with network dentists; includes routine oral exams, X-rays, and cleanings)	100%	50%
Basic services (includes anesthesia, emergency treatment to relieve pain, restorative dentistry, sealants, space maintainers, oral surgery, endodontics, and periodontics)	50%	50%
Major services (includes crown buildups, crowns, prosthetics, inlays, onlays, jackets, posts and cores, and veneers)	50%	50%
Orthodontics	Not covered	Not covered
Enhanced dental benefits for pregnant women* (not subject to plan deductibles with network dentists; includes routine prophylaxis [including prophylaxis for pregnancy gingivitis], periodontal scaling and root planing, and periodontal maintenance)	100%	100%

This is only a summary of the Blue Shield Dental PPO Smile Basic 75/1000/No Ortho/MAC Plan. Please refer to the plan contract and the Evidence of Coverage for a detailed description of covered benefits and limitations.

* For more information about dental services for pregnant women, including the separate address used to process all dental pregnancy service claims, call Customer Service at **(888) 702-4171**.

Note: The reimbursement amount is a percentage of the maximum allowable charge or MAC. When you go to a non-network dentist, you pay the amount above the MAC percentage.

General limitations

Benefits provided are subject to the following limitations:

- Implants (artificial materials, including synthetic bone-grafting materials which are implanted into, onto or under bone or soft tissue) or the removal of implants (surgically or otherwise).
- Crowns, inlays, or onlays, laminate veneers, or other cast- or laboratory-prepared restorations if the tooth can be restored with a filling material (e.g., amalgam, composite resin, or silicate cement).
- Benefits are not provided for general anesthesia or intravenous sedation, except as administered by a licensed dentist in connection with a covered oral surgical procedure.

General exclusions

Benefits are not provided with respect to:

- Charges for services in connection with any treatment to the gums for tumors, cysts, and neoplasms.
- Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation.
- Charges for vestibuloplasty and for any procedure, service, or supply including office visits, examination and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, dysfunction or disease of the temporomandibular joint and its associated structures, including but not limited to myofascial pain dysfunction syndrome.
- Services or supplies provided in connection with a congenital anomaly or development malformation.
- Charges related to prescribed or locally delivered drugs, premedication, analgesia, local anesthetics, sedatives, or periodontal pocket irrigation.
- Charges for services performed by a close relative or by a person who ordinarily resides in the subscriber's or dependent's home.
- Services, procedures, or supplies which are not reasonably necessary for the care of the person's dental condition according to broadly accepted standards of professional care, or which are experimental or investigative in nature, or which do not have uniform professional endorsement.
- Appliances, restorations, or services, including but not limited to equilibration, required solely to change, maintain, or restore vertical dimension, or occlusion or solely for the purpose of splinting.
- Services, procedures, or supplies which are purely cosmetic in nature.
- The replacement of an appliance which has been either lost or stolen.
- Myofunctional therapy; biofeedback procedures; athletic mouthguards; precision, or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures; sealants; charges for acid etching.

- Orthognathic surgery; including but not limited to osteotomy; osteotomy and other services or supplies to augment or reduce the upper or lower jaw.
- Charges for services in connection with orthodontia (Smile Basic, Smile Basic Voluntary, Smile Spectrum 50/1000/No Ortho/MAC, Smile Spectrum 50/1000/No Ortho/U90, Smile Spectrum 50/1500/No Ortho/MAC, Smile Spectrum 50/1500/No Ortho/U90, Smile Spectrum Premier 25/1000/No Ortho/MAC, Smile Spectrum Premier 25/1500/No Ortho/MAC, Smile Spectrum Premier 25/2000/No Ortho/MAC, Smile Spectrum Premier 25/1000/No Ortho/U90, Smile Spectrum Premier 25/1500/No Ortho/U90, Smile Spectrum Premier 25/2000/No Ortho/U90, Smile Spectrum Premier 50/1000/No Ortho/MAC, Smile Spectrum Premier 50/1500/No Ortho/MAC, Smile Spectrum Premier 50/2000/No Ortho/MAC, and Smile Spectrum Premier 50/1000/No Ortho/ U90 only).
- Temporary dental services.
- Extra-oral grafts.
- Hospital costs and any additional fees charged by the dentist for hospital treatment.
- Any service, procedure, or supply for which the prognosis for long-term success is not reasonably favorable as determined by the dental plan administrator and its dental consultants.
- Any service, procedure, or supply for which the person is not legally obligated to pay, or for services for which no charge is made to the person.

Any service, procedure, or supply that is received or started prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have started is defined as follows:

- For full dentures or partial dentures: on the date the final impression is taken.
- For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared.
- For root canal therapy: on the later date the pulp chamber opened or the date canals are explored to the apex.
- For all periodontal surgery: on the date the surgery is actually performed.
- For all other services: on the date the service is performed.

Many benefits have pre-determined annual schedules and frequency limitations based on last delivery date and dental necessity. If you are unsure about the frequency of when a benefit can be accessed, you can call **(888) 702-4171**.

For exact terms and conditions of coverage, please refer to the *Evidence of Coverage* and the *Group Health Service Agreement*.