# Blue Dental℠ EPO Personal

An individual dental plan from Blue Cross Blue Shield of Michigan.

| | In-network | Out-of-network and Blue Par Select℠ |
|---|---|---|
| **Member's responsibility (deductibles, coinsurances and dollar maximums)** | | |
| **Deductibles** | None | Not covered |
| **Coinsurance** | | |
| Class I — Preventive and diagnostic services | 20% | Not Covered |
| Class II — Minor restorative services | 40% | Not Covered |
| Class III — Major restorative services | 50% | Not Covered |
| Class IV — Orthodontic services | Not Covered | Not Covered |
| **Waiting periods** | | |
| Class II — Minor restorative services | 6-month waiting period (except for sealants and emergency palliative) for non-pediatric members | N/A |
| Class III — Major restorative services | 12-month waiting period for non-pediatric members | N/A |
| **Dollar maximums** | | |
| Annual maximum (for Class I, II and III services) | $1,000 for non-pediatric members | N/A |
| Lifetime maximum for TMD benefits | N/A | N/A |
| Out of Pocket Maximum | $700 for one member or $1,400 for two or more members<br>Applies only to essential health benefits for pediatric members | N/A |
| **Class I — Preventive and diagnostic services** | | |
| **Oral exams** | Covered — 80% of approved amount<br>Twice per calendar year | Not Covered |
| **A set (up to 4 films) of bitewing X-rays** | Covered — 80% of approved amount<br>Once per calendar year | Not Covered |
| **Dental prophylaxis (teeth cleaning)** | Covered — 80% of approved amount<br>Three times per calendar year for pediatric members<br>Twice per calendar year for non-pediatric members (we will cover an additional (1) routine cleaning or periodontal maintenance procedure per calendar year with documentation of specific concurrent adverse medical conditions from the provider for non-pediatric members) | Not Covered |

Find other important information about Blues benefits and membership at **bcbsm.com/importantinfo**.

Call a Health Plan Advisor at 1-877-469-2583 if you have any questions.

MyBlue℠

# Blue Dental℠ EPO Personal

| | In-network | Out-of-network and Blue Par Select℠ |
|---|---|---|
| **Class I — Preventive and diagnostic services** *continued* | | |
| **Fluoride treatment for pediatric members** | Covered — 80% of approved amount<br>Two times per calendar year | Not Covered |
| **Oral brush biopsy sample collection** | Covered — 80% of approved amount<br>Two times per calendar year | Not Covered |
| **Class II — Minor restorative services** | | |
| **Fillings – permanent (adult) teeth** | Covered — 60% of approved amount<br>Replacement fillings covered after 48 months or more after initial filling | Not Covered |
| **Fillings — primary (child) teeth** | Covered — 60% of approved amount<br>Replacement fillings covered after 24 months or more after initial filling | Not Covered |
| **Recementation of crowns, veneers, inlays, onlays and bridges** | Covered — 60% of approved amount<br>Three times per tooth per calendar year after six months from original restoration | Not Covered |
| **Simple extractions** | Covered — 60% of approved amount | Not Covered |
| **Root canal treatment — permanent tooth** | Covered — 60% of approved amount<br>Once per tooth per lifetime for a tooth with one or more canals | Not Covered |
| **Periodontal maintenance** | Covered — 60% of approved amount<br>No more than two prophylaxes [cleanings] and/or periodontal prophylaxes or maintenance procedures will be payable in a calendar year for non-pediatric members. No more than three will be payable in a calendar year for pediatric members.<br>We will cover an additional (1) routine cleaning or periodontal maintenance procedure per calendar year with documentation of specific concurrent adverse medical conditions from the provider for non- pediatric members | Not Covered |
| **General anesthesia or IV sedation** | Covered — 60% of approved amount<br>In connection with oral surgery when medically or dentally necessary as determined by BCBSM | Not Covered |
| **Repairs and adjustments of partial or complete dentures** | Covered — 60% of approved amount<br>Six months or more after it is delivered | Not Covered |
| **Relining or rebasing of partials or complete dentures** | Covered — 60% of approved amount<br>Once every 36 months per arch after six months or more after it is delivered | Not Covered |
| **Tissue conditioning** | Covered — 60% of approved amount<br>Once every 36 months per arch | Not Covered |
| **Full-mouth and panoramic x-rays** | Covered — 60% of approved amount<br>Once every 60 months | Not Covered |

# Blue Dental℠ EPO Personal

| | In-network | Out-of-network and Blue Par Select℠ |
|---|---|---|
| **Class II — Minor restorative services** *continued* | | |
| **Pit and fissure sealants — for pediatric members** | Covered — 60% of approved amount<br>Once per tooth every 36 months when applied to the first and second permanent molars | Not Covered |
| **Palliative (emergency) treatment** | Covered — 60% of approved amount | Not Covered |
| **Space maintainers — missing posterior (back) primary teeth — for pediatric members** | Covered — 60% of approved amount<br>Once per quadrant per lifetime | Not Covered |
| **Class III — Major restorative services** | | |
| **Complete dentures** | Covered — 50% of approved amount<br>Once every 84 months | Not Covered |
| **Partial dentures (removable and fixed) for members age 16 or older** | Covered — 50% of approved amount<br>Once every 84 months | Not Covered |
| **Endodontic surgical procedures** | Covered — 50% of approved amount | Not Covered |
| **Onlays, crowns and veneer fillings — permanent teeth — for members age 12 or older** | Covered — 50% of approved amount<br>Once every 84 months per tooth | Not Covered |
| **Scaling and root planing — for members age 12 or older** | Covered — 50% of approved amount<br>Once every 36 months per quadrant for non-pediatric members.<br>Once every 24 months per quadrant for pediatric members. | Not Covered |
| **All other oral surgery** | Covered — 50% of approved amount | Not Covered |
| **All other periodontal surgery** | Covered — 50% of approved amount | Not Covered |
| **Class IV — Orthodontic services** | | |
| **Orthodontic services** | Not covered | |

**Network access information**

With Blue Dental℠ EPO Personal, members must choose a dentist who is a member of the Dental Network of America (DNoA) Preferred Network of PPO dentists.

**DNoA Preferred Network** — Blue Dental members have unmatched access to PPO dentists through the DNoA Preferred Network, which offers nearly 200,000 dentist locations* nationwide. DNoA Preferred Network dentists agree to accept our approved amount as payment in full and participate on all claims. Members also receive discounts on noncovered services when they use PPO dentists. To find a DNoA Preferred Network dentist near you, please visit **bcbsm.com**, click *Find a Doctor* and select *Blue Dental* or call **1-888-826-8152**.

**A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two locations.*

**Note:** If you go to a dentist who is not in-network, you are responsible for all costs for services rendered.

**Note: Pediatric members are members who are under age 19 on the plan's effective date. They remain pediatric members through the end of the calendar year in which they turn 19.**

**Note:** For non-urgent or complex dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination before treatment begins.





CF 13403 AUG 13 R017805