

# Blue Dental<sup>SM</sup> EPO Personal

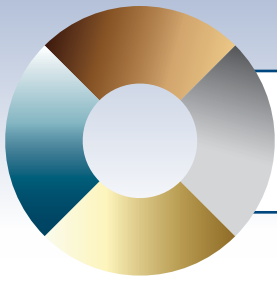
An individual dental plan from Blue Cross Blue Shield of Michigan.

|  | In-network  | Out-of-network and Blue Par Select <sup>SM</sup> |
|--|---|--|
| <b>Member's responsibility (deductibles, coinsurances and dollar maximums)</b> |   |  |
| <b>Deductibles</b>   | None  | Not covered                                      |
| <b>Coinsurance</b>   |   |  |
| 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                                      |
| <b>Waiting periods</b>   |   |  |
| 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  |
| <b>Dollar maximums</b>   |   |  |
| 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  |
| <b>Class I — Preventive and diagnostic services</b>                            |   |  |
| <b>Oral exams</b>  | Covered — 80% of approved amount  | Not Covered                                      |
|  | Twice per calendar year   |  |
| <b>A set (up to 4 films) of bitewing X-rays</b>                                | Covered — 80% of approved amount  | Not Covered                                      |
|  | Once per calendar year  |  |
| <b>Dental prophylaxis (teeth cleaning)</b>                                     | Covered — 80% of approved amount  | Not Covered                                      |
|  | Three times per calendar year for pediatric members<br><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) |  |

Find other important information about Blues benefits and membership at [bcbsm.com/importantinfo](http://bcbsm.com/importantinfo).

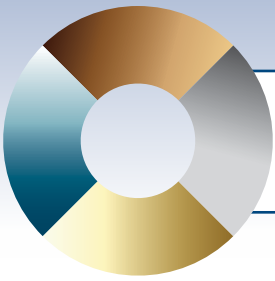
Call a Health Plan Advisor at 1-877-469-2583 if you have any questions.





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| <b>Class I – Preventive and diagnostic services</b> <i>continued</i> |  |  |
| Fluoride treatment for pediatric members                             | Covered – 80% of approved amount   | Not Covered                                      |
|  | Two times per calendar year  |  |
| Oral brush biopsy sample collection                                  | Covered – 80% of approved amount   | Not Covered                                      |
|  | Two times per calendar year  |  |
| <b>Class II – Minor restorative services</b>                         |  |  |
| Fillings – permanent (adult) teeth                                   | Covered – 60% of approved amount   | Not Covered                                      |
|  | Replacement fillings covered after 48 months or more after initial filling   |  |
| Fillings – primary (child) teeth                                     | Covered – 60% of approved amount   | Not Covered                                      |
|  | Replacement fillings covered after 24 months or more after initial filling   |  |
| Recementation of crowns, veneers, inlays, onlays and bridges         | Covered – 60% of approved amount   | Not Covered                                      |
|  | Three times per tooth per calendar year after six months from original restoration   |  |
| Simple extractions   | Covered – 60% of approved amount   | Not Covered                                      |
| Root canal treatment – permanent tooth                               | Covered – 60% of approved amount   | Not Covered                                      |
|  | Once per tooth per lifetime for a tooth with one or more canals  |  |
| Periodontal maintenance  | Covered – 60% of approved amount   | Not Covered                                      |
|  | 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. |  |
|  | 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                    |  |
| General anesthesia or IV sedation                                    | Covered – 60% of approved amount   | Not Covered                                      |
|  | In connection with oral surgery when medically or dentally necessary as determined by BCBSM  |  |
| Repairs and adjustments of partial or complete dentures              | Covered – 60% of approved amount   | Not Covered                                      |
|  | Six months or more after it is delivered   |  |
| Relining or rebasing of partials or complete dentures                | Covered – 60% of approved amount   | Not Covered                                      |
|  | Once every 36 months per arch after six months or more after it is delivered   |  |
| Tissue conditioning  | Covered – 60% of approved amount   | Not Covered                                      |
|  | Once every 36 months per arch  |  |
| Full-mouth and panoramic x-rays                                      | Covered – 60% of approved amount   | Not Covered                                      |
|  | Once every 60 months   |  |



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| <b>Class II — Minor restorative services</b> <i>continued</i>                      |  |  |
| Pit and fissure sealants — for pediatric members                                   | Covered — 60% of approved amount   | Not Covered                                      |
|  | Once per tooth every 36 months when applied to the first and second permanent molars |  |
| 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   | Not Covered                                      |
|  | Once per quadrant per lifetime   |  |
| <b>Class III — Major restorative services</b>                                      |  |  |
| Complete dentures  | Covered — 50% of approved amount   | Not Covered                                      |
|  | Once every 84 months   |  |
| Partial dentures (removable and fixed) for members age 16 or older                 | Covered — 50% of approved amount   | Not Covered                                      |
|  | Once every 84 months   |  |
| 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   | Not Covered                                      |
|  | Once every 84 months per tooth   |  |
| Scaling and root planing — for members age 12 or older                             | Covered — 50% of approved amount   | Not Covered                                      |
|  | Once every 36 months per quadrant for non-pediatric members.                         |  |
|  | Once every 24 months per quadrant for pediatric members.                             |  |
| All other oral surgery   | Covered — 50% of approved amount   | Not Covered                                      |
| All other periodontal surgery  | Covered — 50% of approved amount   | Not Covered                                      |
| <b>Class IV — Orthodontic services</b>   |  |  |
| Orthodontic services   | Not covered  |  |

## Network access information

With Blue Dental<sup>SM</sup> 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](http://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.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

