



**Blue Cross
Blue Shield**
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

EMERGING MARKETS

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Effective Date: 08/01/2020

Dental Coverage

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 copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Network access information

With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com 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 offices is two dentist locations.*

Blue Par SelectSM arrangement- Most non-PPO(out-of-network) dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services, and members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit mibluedentist.com.

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn age 26, provided all eligibility requirements are met.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services)	None (covered at 100%)
<ul style="list-style-type: none"> Class I services 	

ADM MOS816 DNTL;ADM MOS816 VIS;ADM PLANYSR JAN;ADM SPA-HEQ-DEN;ADM SPA-HEQ-VIS;ASCMOD 6352 VIS;ASCMOD 6915;BLUE DENTAL;BLUE VISION;BV-PL;BV-SGC;BV-UVC;BVC-\$7.50;BVFL;CDH FSADCFSA DC;CDH FSADCFSA VC;DO-CL-12;DO-DI;DO-PC4X;DO-PPO;DO-RCR;L DORAF;PK634

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Benefits	Coverage
• Class II services	25%
• Class III services	50%
• Class IV services	50%
Dollar maximums	\$2,600 per member
• Annual maximum for Class I, II and III services	
• Lifetime maximum for Class IV services	\$2,400 per member

Class I services

Benefits	Coverage
Oral exams	100% of approved amount Note: Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount Note: Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount Note: Once every 60 months
Prophylaxis (cleaning)	100% of approved amount Note: Two per calendar year
Sealants - for members age 19 and younger	100% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount Note: Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount Note: Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	75% of approved amount Note: Replacement fillings covered after 12 months or more after initial filling
Fillings - primary (child) teeth	75% of approved amount Note: Replacement fillings covered after 12 months or more after initial filling
Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older Note: BCBSM will pay for replacement cast restorations (onlays, and veneers) once every 36 months per member. This period begins on the date the last restoration was cemented in place.	75% of approved amount Note: Once every 36 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	75% of approved amount Note: Three times per tooth per calendar year after six months from original restoration
Oral surgery	75% of approved amount
Root canal treatment	75% of approved amount Note: Once per tooth per lifetime; retreatment of previous root canal therapy (after 12 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	75% of approved amount Note: Once every 24 months per quadrant
Limited occlusal adjustments	75% of approved amount Note: Limited occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	75% of approved amount Note: Once every 12 months

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Benefits	Coverage
General anesthesia or IV sedation	75% of approved amount Note: When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	75% of approved amount Note: Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	75% of approved amount Note: Once per arch in any 36 consecutive months
Tissue conditioning	75% of approved amount Note: Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount Note: Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount Note: Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31 Note: Subject to an annual benefit maximum of \$1,200 per member per calendar year

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Note: For non-urgent, complex or expensive 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.

Vision Coverage

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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	\$5 copay	\$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay
Medically necessary contact lenses	\$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay

Note: No copay is required for prescribed contact lenses that are not medically necessary.

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	\$5 copay	Reimbursement up to \$50 less \$5 copay (member responsible for any difference)

One eye exam in any period of 12 **consecutive** months

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
<p>Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.</p> <ul style="list-style-type: none"> Progressive Lenses - Covered when rendered by a VSP network doctor Ultraviolet Coating - Covered when rendered by a VSP network doctor Scratch Guard Coating - Covered when rendered by a VSP network doctor 	<p>\$7.50 copay (one copay applies to both lenses and frames)</p> <p>One pair of lenses, with or without frames, in any period of 12 consecutive months</p>	<p>Reimbursement up to approved amount based on lens type less \$7.50 copay (member responsible for any difference)</p>
<p>Standard frames</p> <p>Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.</p>	<p>Covered up to \$150 (member responsible for any cost exceeding approved amount) less less \$7.50 copay (one copay applies to both frames and lenses)</p> <p>One frame in any period of 12 consecutive months</p>	<p>Reimbursement up to \$70 less \$7.50 copay (member responsible for any difference)</p>

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	\$7.50 copay	Reimbursement up to \$210 less \$7.50 copay (member responsible for any difference)

Contact lenses up to the allowance in any period of 12 **consecutive** months

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Benefits	VSP network doctor	Non-VSP provider
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	Covered up to a maximum payment of \$200 (member responsible for any difference)	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Contact lenses up to the allowance in any period of 12 consecutive months		

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