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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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.

Dentist information
With Blue Dental EPO, you **must** choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the United States through the Blue Dental PPO network. Tier 1 PPO dentists agree to accept our PPO approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 1 PPO dentist near you, log into your member account at **bcbsm.com** or call **1-888-826-8152.**

Note: If you go to a non-PPO (out-of-network) dentist, you are responsible for all costs for services rendered.

Eligibility information

Member	Eligibility Criteria
Dependents	• 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	In-network	Out-of-network
Deductible	None	Not applicable
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)	Not covered
• Class II services	None (covered at 100%)	Not covered
• Class III services	15%	Not covered
• Class IV services	30%	Not covered
Dollar maximums • Annual maximum for Class I, II and III services	$2,600 per member per calendar year	Not applicable
• Lifetime maximum for Class IV services	$2,400 per member	Not applicable

Class I services

Benefits	In-network	Out-of-network
Oral exams	100% of approved amount, twice per calendar year	Not covered
A set (up to 4 films) of bitewing x-rays	100% of approved amount, once per calendar year	Not covered
Panoramic or full-mouth x-rays	100% of approved amount, once every 60 months	Not covered
Prophylaxis (cleaning)	100% of approved amount, twice per calendar year	Not covered
Sealants - for members age 19 and younger	100% of approved amount, once per tooth in any 36 consecutive months when applied to the first and second permanent molars. This period begins on the date of the member's first treatment.	Not covered
Emergency palliative treatment	100% of approved amount	100% of approved amount
Fluoride treatments	100% of approved amount, two per calendar year	Not covered
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount, once per quadrant per lifetime	Not covered
Periodontic maintenance	100% of approved amount, up to four periodontal maintenance cleanings per calendar year. **Note:** The patient must have a documented history of periodontal disease, prior to and during the treatment phase	Not covered

Note: Twice per calendar year
Note: Benefits are payable for up to four periodontal maintenance cleanings per calendar year during the first two years immediately following periodontal scaling and root planing or periodontal surgery.

Class II services

Benefits	In-network	Out-of-network
Fillings - permanent (adult) teeth	100% of approved amount, replacement fillings covered after 12 months or more after initial filling	Not covered
Fillings - primary (child) teeth	100% of approved amount, replacement fillings covered after 12 months or more after initial filling	Not covered
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.	100% of approved amount, once every 60 months per tooth	Not covered
Recementation of crowns, veneers, inlays, onlays and bridges	100% of approved amount, three times per tooth per calendar year after six months from original restoration	Not covered
Oral surgery	100% of approved amount	Not covered
Root canal treatment	100% of approved amount, once per tooth per lifetime; retreatment of previous root canal therapy once per tooth per lifetime	Not covered
Scaling and root planing	100% of approved amount, once every 24 months per quadrant	Not covered
Limited occlusal adjustments	100% of approved amount, **limited** occlusal adjustments covered up to five times in any 60 consecutive months	Not covered

Benefits	In-network	Out-of-network
Occlusal biteguards	100% of approved amount, once every 12 months	Not covered
General anesthesia or IV sedation	100% of approved amount, when medically necessary and performed with oral surgery	Not covered
Repairs and adjustments of a partial or complete denture	100% of approved amount, six months or more after denture is delivered	Not covered
Relining or rebasing of a partial or complete denture	100% of approved amount, once per arch in any 36 consecutive months	Not covered
Tissue conditioning	100% of approved amount, once per arch in any 36 consecutive months	Not covered

Class III services

Benefits	In-network	Out-of-network
Removable dentures (complete and partial)	85% of approved amount, once every 60 months	Not covered
Bridges (fixed partial dentures) - for members age 16 and older	85% of approved amount, once every 60 months	Not covered
Endosteal implants - for members age 16 and older who are covered at the time of the actual implant placement; subject to an annual benefit maximum of $1,200 per member, per calendar year	85% of approved amount, once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31	Not covered

Class IV services

Benefits	In-network	Out-of-network
Minor treatment for tooth guidance appliances	70% of approved amount	Not covered
Minor treatment to control harmful habits	70% of approved amount	Not covered
Interceptive and comprehensive orthodontic treatment	70% of approved amount	Not covered
Post-treatment stabilization	70% of approved amount	Not covered
Cephalometric film (skull) and diagnostic photos	70% of approved amount	Not covered

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. **Services received outside the dental network are not covered.**