

**BLUEDENTAL PPO – 10+ SUMMARY OF
BENEFITS 25 - \$2000 A2 O MAC w/
\$1500 Adult & Child Ortho**

| Plan Benefit Structure | | | | |
|--|--|------------|----------------|------------|
| Benefit Maximum per Member per Calendar Year All services, except Type I | | | \$2,000 | |
| Annual Deductible Deductible waived for Type I services | | | | |
| Individual | | | \$25 | |
| Family | | | \$75 | |
| Benefit Category | In-Network | | Out-of-Network | |
| | Plan Pays | You Pay | Plan Pays | You Pay |
| Type I | 100% | 0% | 80% | 20% |
| | <i>Type I services do not count toward the calendar-year maximum</i> Deductible does not apply | | | |
| Type II | 90% | 10% | 70% | 30% |
| After meeting deductible | | | | |
| Type III | 60% | 40% | 40% | 60% |
| After meeting deductible | | | | |
| Type IV | 50% | 50% | 50% | 50% |
| \$1,500 - Adult & Child Ortho. | | | | |
| Type I Covered Services | | | | |
| Oral Exams | Two per year ¹ in any combination of periodic, limited, or comprehensive exams | | | |
| Prophylaxis | Two per year – Type III periodontal maintenance <u>does not</u> count toward max of two cleanings | | | |
| Bitewing X-rays ² | Two per year | | | |
| Periapical X-rays ² | Four films per year | | | |
| Full Mouth X-rays ² | One per five-year period | | | |
| Topical Fluoride | Through age 15 – one per calendar year | | | |
| Sealants | Through age 15 – one per lifetime | | | |
| Space maintainers | Through age 15 | | | |
| Type II Covered Services | | | | |
| Amalgam Fillings – Restorative | One treatment per tooth in any two-year period (limit based on amalgam and composite fillings combined) | | | |
| Composite Fillings – Anterior (Front) Teeth | One treatment per tooth in any two-year period; (limit based on amalgam and composite fillings combined) | | | |
| Composite Fillings – Restoration of Posterior/Bicuspid (all except front) Teeth | One treatment per tooth in any two-year period; (limit based on amalgam and composite fillings combined) | | | |
| Emergency Palliative Treatment | Covered for emergency treatment of dental pain | | | |
| Endodontics – Pulpal Therapy | One treatment per tooth in any two-year period | | | |
| Periodontics – Surgical and Non-surgical | Surgical – One procedure per three-year period Non-Surgical – One per two-year period | | | |
| Surgical Simple Extractions | Covered | | | |
| Oral Appliances for Treatment of Bruxism | Covered | | | |
| Type III Covered Services | | | | |
| Prosthodontics – Bridges & Dentures | Seven-year replacement limit | | | |
| General Anesthesia | Limited Coverage per BCBSAZ dental coverage guidelines ³ | | | |
| Crowns/Inlays/Onlays | Seven-year replacement limit | | | |
| Implants | Covered | | | |
| Type IV Covered Services | | | | |
| Orthodontics | Covered. Orthodontia is subject to certain additional limitations. | | | |
| Out of Network Reimbursement | MAC (Maximum Allowable Charge) | | | |
| Maximum Rollover Benefit | Covered | | | |
| Provider Network | Includes both Blue PPO and Blue PPO Prime | | | |

¹ All "per year" benefits mean per calendar year.

² Any combination of x-rays billed on the same date of treatment cannot exceed the allowed amount for a full mouth x-ray benefit.

³ BCBSAZ Dental Coverage Guidelines are available upon request. Not all dentally necessary services are covered benefits.

In-Network Providers

“In-network” dental providers have contracts with Blue Cross Blue Shield of Arizona (BCBSAZ) or with BCBSAZ’s independent dental network vendor. In-network providers accept negotiated fees as payment in full for covered dental services, and file a member’s claims with BCBSAZ. Members usually have lower out-of-pocket costs with in-network providers.

Out-of-Network Providers

“Out-of-network” providers have no contract with BCBSAZ or with BCBSAZ’s independent dental network vendor. Out-of-network providers set their own rates, can collect up to full billed charges from members, and have no obligation to file members’ claims.

For out-of-network providers within Arizona, BCBSAZ reimburses the member based on the lesser of BCBSAZ’s established in-network fee schedule amount or the dentist’s actual billed charge. If the provider is located outside Arizona, reimbursement is based on the lesser of billed charges or the fee schedule of the independent dental network vendor.

Example

The following example shows how use of an in-network provider may save you money. This example assumes:

- You have already met your annual deductible
- You have 80% coinsurance for in-network providers
- You have 80% coinsurance for out-of-network providers
- Your dentist’s billed charge is \$150
- BCBSAZ’s established in-network fee is \$100

| In-Network Provider | | Out-of-Network Provider | |
|---------------------------------|--------------|----------------------------------|-------------|
| Billed charge | \$150 | Billed charge | \$150 |
| BCBSAZ in-network fee | \$100 | BCBSAZ in-network fee | \$100 |
| BCBSAZ pays (80% x \$100) | \$ 80 | BCBSAZ pays (80% x \$100) | \$ 80 |
| | | | |
| You pay (20% x \$100) | \$ 20 | You pay (20% x \$100) | \$ 20 |
| | | Plus difference of billed charge | \$ 50 |
| | | | |
| Your Out-of-Pocket Cost: | \$ 20 | Your Out-of-Pocket Cost: | \$70 |

While your actual expenses will vary, in this example, you would have saved \$50 by using an in-network provider.

Optional Pre-determination

If your dentist has recommended services and you are concerned about coverage or costs, your dentist can ask BCBSAZ for a pre-treatment estimate, called a “pre-determination.” BCBSAZ will review your dentist’s proposed treatment and send your dentist information explaining what services will be covered and your estimated out-of-pocket costs for these services. A pre-determination can help you better understand what will be covered and the amount you will need to pay.

Preventive Rewards

Primary subscriber will receive a \$20 payment from BCBSAZ for each family member who receives two cleanings during the plan year from a participating network dentist.

Prevention Plus

All diabetic and expecting mothers are eligible for coverage of one additional dental cleaning procedure or one additional periodontal maintenance procedure. For members who have enrolled in the program, extended preventive benefits will remain available for the duration of these conditions.

Rollover Benefits

Member may be eligible for a rollover of a portion of his or her unused Annual Maximum for Class I, II, and III Services. If a Member submits at least one claim for a covered cleaning during a Calendar Year and, in that Calendar Year, receives Benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Rollover Benefit Threshold, he or she may be entitled to Rollover Benefits. Rollover Benefits can accrue and are tracked by the Plan. If a Member reaches his or her Annual Maximum for Class I, II, and III Services, the Plan will pay Benefits up to the Rollover Maximum. The amount of Rollover Benefits may not be greater than the Rollover Maximum. A Member’s Rollover Benefits may be eliminated, and the accrued benefit lost, if there is a break in coverage of any length of time, for any reason, or if the Rollover Benefit Threshold is exceeded in any given Calendar Year. Under this Contract, the Rollover Benefit Threshold and Rollover Maximum are as follows:

Rollover Benefit Threshold.....\$1,000
(Calculated at 50% of Annual Maximum)

| | |
|--|---|
| | Rollover Maximum..... \$2,500 (Calculated at 125% of Annual Maximum Rollover Benefit is calculated at 50% of Annual Maximum less Benefits paid. |
|--|---|

BCBSAZ Standard PPO Exclusions and Limitations

Type I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients); Preventive Reward: Primary subscriber will receive a \$20 payment from BCBSAZ for each family member that receives two cleanings during the plan year from a participating PPO network dentist. Contact your Benefit Administrator for details.
4. One topical fluoride per Calendar Year, to age 16
5. Bitewing x-rays, 2 per Calendar Year
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months
8. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)
9. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)

Type II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
4. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
5. Antibiotic injections administered by a dentist
6. Occlusal orthotic device for TMD (D7880), by report, one per five years
7. Oral surgery, including postoperative care for:
 - a. Removal of teeth, including impacted teeth
 - b. Extraction of tooth root
 - c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
 - d. Alveolectomy, alveoplasty, and frenectomy
 - e. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
 - f. Tooth reimplantation and/or stabilization; tooth transplantation
 - g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
8. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
 - a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
 - b. Pulpotomy
 - c. Apicoectomy
 - d. Retrograde fillings, per root per lifetime
9. Periodontic services, limited to:
 - a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
 - b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
 - c. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years
 - d. Occlusal adjustment performed with covered surgery
 - e. Gingivectomy
 - f. Osseous surgery including flap entry and closure
 - g. One pedicle or free soft tissue graft per site per lifetime
 - h. One appliance (night guards) per 5 years within 6 months of osseous surgery

- i. One full mouth debridement per lifetime

Type III. Major Services:

1. One study model per 36 months
2. Crown build-up for non-vital teeth
3. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
4. One repair of dentures or fixed bridgework per 24 months
5. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery, or implant placement procedures
6. Restoration services, limited to:
 - a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, one per 60 months from the original date of placement, per permanent tooth
 - b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
 - c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
 - d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
7. Prosthetic services, limited to:
 - a. Initial placement of removable dentures or fixed bridges
 - b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
 - c. Addition of teeth to existing partial denture
 - d. One relining or rebasing of existing removable dentures per 24 months
8. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Type IV. Orthodontia services and tooth extractions relating to those services, listed as a covered service on the member's summary of benefits.

Diagnostic services, active and retention treatment to include removable, fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:

1. Services which are covered under Medicare, worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony (except for D7880).
11. Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.