

# BluePreferred Dental

## Benefit Summary Plan 7P: 25/2000



An Independent Licensee of the Blue Cross and Blue Shield Association

PLAN BENEFIT STRUCTURE	
Benefit Maximum per Member per Calendar Year <sup>1</sup> All services except Type I services count toward the maximum	\$2,000
Annual Deductible <sup>1</sup> Deductible waived for Type I services. Individual Family	\$25 \$75

BENEFIT CATEGORY	IN-NETWORK		OUT-OF-NETWORK	
	PLAN PAYS	YOU PAY	PLAN PAYS	YOU PAY
Type I	100%	0%	100%	0%
	Type I services do not count toward the calendar year benefit maximum; deductible does not apply			
Type II	90%	10%	90%	10%
	After meeting deductible			
Type III	60%	40%	60%	40%
	After meeting deductible; 12 month waiting period may apply			
Type IV	For orthodontia benefits, if any, please see the separate orthodontia benefit summary. Orthodontia is subject to certain additional limitations.			

TYPE I COVERED SERVICES <sup>1</sup>	
Oral exams	Two per year <sup>2</sup> in any combination of periodic, limited, or comprehensive exams
Prophylaxis – Cleanings	Two per year – Type II periodontal maintenance procedures, if any, count toward this maximum of two cleanings
Bitewing X-rays <sup>3</sup>	One set per year
Periapical X-rays <sup>3</sup>	Four films per year
Full Mouth X-rays <sup>3</sup>	One per five year period
Topical Fluoride	Through age 18 – One per year
Sealants	Through age 15 – permanent molars and bicuspid only, once per three year period
Space Maintainers	Through age 15

TYPE II COVERED SERVICES <sup>1</sup>	
Amalgam Fillings	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 – Posterior/Bicuspid (all except front) Teeth	One treatment per tooth in any two year period (limit based on amalgam and composite fillings combined); subject to processing based on the least expensive available treatment (LEAT).
Emergency Palliative Treatment	Covered for emergency treatment of dental pain
Endodontics – Pulpal Therapy	One treatment per tooth in any two year period
Periodontics – Non Surgical	One per two year period – Periodontal maintenance procedures are not included in this limit, but are counted toward the prophylaxis limit.
Simple Extractions	Surgical extractions covered under Type III
Oral Appliances for Treatment of Bruxism	Covered

TYPE III COVERED SERVICES <sup>1</sup>	
Claims for certain Type III services are subject to processing based on the least expensive available treatment (LEAT).	
Prosthodontics – Bridges & Dentures	Five year replacement limit
Oral Surgery – Extractions	Limited Coverage
General Anesthesia	Limited Coverage per BCBSAZ dental coverage guidelines <sup>4</sup>

**TYPE III COVERED SERVICES<sup>1</sup> (continued)**

Endodontics – Root Canal	One treatment per tooth in any two year period
Crowns/Inlays/Onlays	Five year replacement limit
Periodontics – Surgical	One procedure per three year period

<sup>1</sup> Only the allowed amount, as based on LEAT, if applicable, (and not billed charges) counts to satisfy the deductible. Only the BCBSAZ portion of the allowed amount counts toward the calendar year benefit maximum. Any services in excess of a benefit limit or provided after you reach the calendar year benefit maximum are not covered.

<sup>2</sup> All “per year” benefits mean per calendar year.

<sup>3</sup> Any combination of x-rays billed on the same date of treatment cannot exceed the allowed amount for a full mouth x-ray benefit.

<sup>4</sup> 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.

For both in and out of network providers, reimbursement for restorative services is also subject to analysis for Least Expensive Available Treatment (LEAT), as explained below.

**Example**

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

- o you have already met your annual deductible
- o you have 90% coinsurance for in-network providers
- o you have 90% coinsurance for out-of-network providers
- o your dentist’s billed charge is \$150
- o BCBSAZ’s established in-network fee is \$100
- o LEAT analysis (see description below) does not apply

<b>In-Network Provider</b>		<b>Out-of-Network Provider</b>	
Billed charge	\$150	Billed charge	\$150
BCBSAZ in-network fee	\$100	BCBSAZ in-network fee	\$100
BCBSAZ pays (90% x \$100)	\$90	BCBSAZ pays (90% x \$100)	\$90
You pay (10% x \$100)	\$10	You pay (10% x \$100)	\$10
		Plus difference of billed charge	\$50
<i>Your Out-of-Pocket Cost:</i>	\$10	<i>Your Out-of-Pocket Cost:</i>	\$60

While your actual expenses will vary, in this example you would have saved \$50 by using an in-network provider. The above example does not show how LEAT analysis would affect cost sharing.

**Least Expensive Available Treatment (LEAT)**

There may be several methods for treating a specific dental condition. All claims for restorative services such as fillings and crowns are subject to analysis for the least expensive available treatment (LEAT). Benefits for certain restorative procedures will be limited only to the LEAT. For these procedures, BCBSAZ will only pay benefits up to the LEAT fee. You may elect to receive a covered service that is more costly than the LEAT but you will be responsible for your cost-share based on the LEAT, and you will also pay the difference between the fee for the LEAT and the more costly treatment (“LEAT remainder”). Any payment you make for this LEAT remainder will not count toward deductible.

**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.

## Waiting Periods

A waiting period is a specific amount of time that you will not have coverage for a type of service under your plan. Waiting periods may apply. Please refer to your employer's coverage guidelines for details. If you are unsure about whether a waiting period applies to a needed service, you may also call BCBSAZ customer service.

## Maximum Carryover Provision

This feature allows members, in some circumstances, to carry over unused benefit dollars from one year into the next. Members can take advantage of the Maximum Carryover Provision when the following both happen during the same calendar year:

1. BCBSAZ pays at least one claim.
2. Total claims paid by BCBSAZ do not exceed \$500.

If both of these criteria are satisfied, a member will accumulate a carryover credit of up to \$250, over and above the annual benefit maximum, to be available in future years. Members may continue to accumulate carryover dollars for every calendar year in which the member meets the carryover requirements, up to a maximum of \$1,000 total carryover dollars at a time.

## Prevention + 1 Feature

All diabetic and pregnant members are eligible for coverage of one additional dental cleaning procedure or one additional periodontal maintenance procedure per year. Members must enroll in the program and the extended benefits will remain available to members for the duration of these conditions. Please call the customer service number on your dental ID card to learn how to enroll in the program.

## Exclusions and General Limitations

Notwithstanding any other provision in this benefit plan, no benefits will be paid for expenses associated with the following:

- Alternative Dentistry – Non-traditional or alternative dental therapies, interventions, services and procedures; naturopathic and homeopathic dentistry; diet therapies; nutritional or lifestyle therapies
- Appliances, procedures, devices and services necessary to alter vertical dimension and/or restore an occlusion
- Athletic Mouth Guards – including but not limited to, any procedures and services necessary to fabricate or create such mouth guards
- Behavior management of any kind
- Benefit-specific exclusions and services in excess of limitations listed in this book under particular benefits
- Biologic materials to aid in tissue regeneration
- Bleaching of any kind; both internal and external bleaching
- Body Art, Piercing and Tattooing – Services related to body piercing, cosmetic implants, body art, tattooing and any related complications
- Charges associated with the preparation, copying or production of health records
- Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan
- CT scans (e.g., cone beam)
- Correction of congenital malformations except as required by state law for newborns, adopted children and children placed for adoption
- Cosmetic Services and Any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes
- Counseling – Counseling and behavioral modification services
- Court-Ordered Services – Court-ordered testing, treatment and therapy, unless such services are otherwise covered under this plan as determined by BCBSAZ
- Deep sedation and general anesthesia, except as stated in this plan
- Dental implants and any related services or treatment for complications
- Enamel microabrasion
- Expenses for services that exceed benefit limitations
- Experimental or investigational services
- Fees – Fees for unspecified adjunctive procedures, by report
- Fees – Fees other than for dentally appropriate, in-person, direct member services
- Free Services – Services you receive at no charge or for which you have no legal obligation to pay
- Gold foil restorations
- Government Services – Services provided at no charge to the member through a governmental program or facility
- Inpatient or outpatient facility services – any facility charges associated with covered professional services provided in an inpatient or outpatient facility
- Laboratory and pathology services
- Laminate veneers
- Local, regional block, and trigeminal division block anesthesia
- Locally administered antibiotics
- Major restorative and prosthodontics services performed on other than a permanent tooth
- Maxillofacial prosthetics and any related services
- Medications Dispensed in a Dentist's Office – prescription medications and over-the-counter medications, including pharmaceutical manufacturers' samples, dispensed to the patient in a dentist's office by any mode of administration. This does not include eligible injectable medications administered in the dentist's office
- Non- Dentally Necessary Services – services that are not dentally necessary as determined by BCBSAZ. BCBSAZ may not be able to determine dental necessity until after services are rendered
- Nitrous oxide; oral or intravenous conscious sedation; oral, intravenous or intramuscular analgesics or anxiolytics.
- Occlusal guards for the treatment of temporomandibular joint syndrome or sleep apnea – including but not limited to, any procedures and services necessary to fabricate or create such mouth guards
- Office visit for observation, during which no services are provided
- Oral hygiene instruction, except when provided as an integral part of a routine covered oral examination.
- Orthodontic services and tooth extractions relating to those services, unless otherwise specifically covered under a contract rider and listed as a covered service on the member's schedule page
- Over-the-Counter Items – Medications, devices, equipment and supplies that are lawfully obtainable without a prescription
- Personal Comfort Items – Services intended primarily for assistance in daily living, socialization, personal comfort, convenience and other non-medical reasons
- Screening Tests – Any testing, including genetic and chromosomal testing, performed on an individual who does not have a specific diagnosis or acute signs or symptoms of a condition or disease for which the test is being performed, regardless of whether the individual has a family history or other risk factors for the disease or condition, except as stated in this plan
- Services and Supplies Not Provided by a Dentist – except dental prophylaxis and root planing performed by a licensed dental hygienist under the supervision and direction of a dentist

- Services for Idiopathic Environmental Intolerance – Services associated with environmental intolerance from unknown causes (idiopathic), multiple chemical sensitivity, the diagnosis or treatment of environmental illness (clinical ecology), such as chemical sensitivity or toxicity from exposure to atmospheric or environmental contaminants, pesticides or herbicides
- Services from a Family Member – Services delivered by an eligible provider who is a member of your immediate family. "Immediate family" means your parents, siblings, children, stepparents, stepchildren, spouse, grandparents, grandchildren and anyone related to you by marriage to the same degree as any of the preceding individuals. When a provider is also the covered person, services rendered by that provider for himself or herself are also excluded from coverage
- Services from ineligible providers
- Services Paid for By Other Organizations – Services customarily paid for by an employer, such as worksite or ergonomic evaluations; the government; a school; biotechnical, pharmaceutical or dental device industry sources; or other individuals and organizations
- Services prior to effective date
- Services provided after the member's coverage termination date
- Services related to or associated with noncovered services
- Skin grafts
- Telephonic and electronic consultations
- Therapy or treatment of the temporomandibular joint, orthognathic surgery, or ridge augmentation
- Training and education
- Transportation – Transport services and travel expenses
- Workers' Compensation – Illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election

THIS IS ONLY A BRIEF SUMMARY OF THIS BENEFIT PLAN. A COMPLETE LISTING OF ALL BENEFITS, LIMITATIONS AND EXCLUSIONS IS IN THE BENEFIT PLAN BOOKLET AND IS AVAILABLE PRIOR TO ENROLLMENT UPON REQUEST. IF THE BENEFITS ON THIS SUMMARY DIFFER FROM THOSE STATED IN THE BENEFIT PLAN BOOKLET, THE TERMS OF THE BENEFIT PLAN BOOKLET APPLY.



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