BLUEDENTAL PPO – 10+
SUMMARY OF BENEFITS
50 - $1500 A290 V

Plan Benefit Structure	
Benefit Maximum per Member per Calendar Year All services, except Type I	**$1,500**
Annual Deductible Deductible waived for Type I services **Individual** **Family**	 **$50** **$150**

Benefit Category	**In-Network**		**Out-of-Network**	
	Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
Type I	**100%**	**0%**	**80%**	**20%**
	Type I services do not count toward the calendar-year maximum Deductible does not apply			
Type II	**80%**	**20%**	**60%**	**40%**
	After meeting deductible			
Type III	**50%**	**50%**	**40%**	**60%**
	After meeting deductible			
Type IV	**0%**	**100%**	**0%**	**100%**
	Orthodontic Rider Available. See description in Type IV section below.			

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 does not 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	To age 16 – one per calendar year
Sealants	To age 16 – one per lifetime
Space maintainers	To age 16
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	One treatment per tooth in any two-year period; (limit based on amalgam and composite fillings combined)
Periodontics – Surgical and Non-surgical	Surgical – One procedure per three-year period Non-Surgical – One per two-year period
Emergency Palliative Treatment	Covered for emergency treatment of dental pain
Endodontics – Pulpal Therapy	One treatment per tooth in any 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	Not Covered
Type IV Covered Services	
Orthodontics	For orthodontia benefits, if any, please see the separate orthodontia benefit summary. Orthodontia is subject to certain additional limitations.
Out of Network Reimbursement	90th of Usual, Customary and Reasonable
Maximum Rollover Benefit	Not 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
- BCBSAZ's established out-of-network maximum reimbursement is $120

In-Network Provider		Out-of-Network Provider	
Billed charge	$150	Billed charge	$150
BCBSAZ in-network fee	$100	BCBSAZ maximum reimburse	$120
BCBSAZ pays (80% x $100)	$ 80	BCBSAZ pays (80% x $120)	$ 96
You pay (20% x $100)	$ 20	You pay (20% x $120)	$ 24
		Plus difference of billed charge	$ 30
Your Out-of-Pocket Cost:	**$ 20**	**Your Out-of-Pocket Cost:**	**$54**

While your actual expenses will vary, in this example, you would have saved $34 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.

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.

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)
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 (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.

    b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place 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, unless otherwise specifically covered under a contract rider and 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. Implants and related Services; 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.