Blue Dental PPO
Benefits-at-a-Glance

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 or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information

With Blue Dental PPO Plus, 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.[1]

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – 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**.

[1]Blue Dental

Blue Par Select^{SM} arrangement – Most non-PPO 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 – 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.

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

Deductible	
• Applies to Class II and Class III services only	$50 per member limited to a maximum of $150 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services)	
• Class I services	None (covered at 100% of approved amount)
• Class II services	20% of approved amount
• Class III services	50% of approved amount
• Class IV services	Not covered
Dollar maximums	
• Annual maximum for Class I, II and III services	$3,000 per member
• Lifetime maximum for Class IV services	Not applicable

Class I services

Oral exams	100% of approved amount, twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount, twice per calendar year
Full-mouth and panoramic x-rays	100% of approved amount, once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount, once every six months
Pit and fissure sealants – for members age 19 and younger	100% of approved amount, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatments – for members under age 19	100% of approved amount, two per calendar year
Space maintainers – missing posterior (back) primary teeth – for members under age 19	100% of approved amount, once per quadrant per lifetime

Class II services

Fillings – permanent (adult) teeth	80% of approved amount after deductible, replacement fillings covered after 24 months or more after initial filling
Fillings – primary (baby) teeth	80% of approved amount after deductible, replacement fillings covered after 12 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount after deductible, three times per tooth per calendar year after six months from original restoration
Oral surgery including extractions	80% of approved amount after deductible
Root canal treatment – permanent tooth	80% of approved amount after deductible, once every 12 months for tooth with one or more canals
Scaling and root planing	80% of approved amount after deductible, once every 24 months per quadrant
Limited occlusal adjustments	80% of approved amount after deductible, **limited** occlusal adjustments covered up to five times in a 60-month period
General anesthesia or IV sedation	80% of approved amount after deductible, when medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	80% of approved amount after deductible, six months or more after it is delivered
Relining or rebasing of a partial or complete denture	80% of approved amount after deductible, once every 36 months per arch
Tissue conditioning	80% of approved amount after deductible, once every 36 months per arch

Class III services

Occlusal biteguards	50% of approved amount after deductible, once every 12 months
Removable dentures (complete and partial)	50% of approved amount after deductible, once every 60 months
Onlays, crowns and veneer fillings – permanent teeth – for members age 12 and older	50% of approved amount after deductible, once every 60 months per tooth
Bridges (fixed partial dentures) – for members age 16 and older	50% of approved amount after deductible, once every 60 months after original was delivered
Endosteal implants – for members age 16 and older who are covered at the time of the actual implant placement	50% of approved amount after deductible, once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	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.