

BlueDental PPO Summary of Benefits
PPO 50 \$1500 A V MAC
1/1/2025

Plan Benefit Structure				
Benefit Maximum per Member per Calendar Year ¹ All services, except Type I		In-Network (INN)		Out-of-Network (OON)
		\$1,500		\$1,500
Annual Deductible ¹ Deductible waived for Type I services				
Individual		\$50		\$50
Family		\$150		\$150
Benefit Category ⁴	In-Network (INN)		Out-of-Network (OON)	
	Plan Pays	You Pay	Plan Pays	You Pay
Type I: Preventive Covered Services ²	100%	0%	80%	20%
Oral Exams				
Prophylaxis				
Bitewing X-rays ³				
Periapical X-rays ³				
Full Mouth X-rays ³				
Topical Fluoride				
Sealants				
Space Maintainers				
Type II: Basic Covered Services ² (after meeting deductible)				
Fillings - Composite and Amalgam				
Emergency Palliative Treatment				
Oral Surgery - Simple Extractions				
Oral Appliances for Treatment of Bruxism				
Type III: Endodontics ²	50%	50%	40%	60%
Root canals / Pulpal Therapy				
Type III: Periodontics ²	50%	50%	40%	60%
Non-Surgical / Surgical (root planing and therapy)				
Type III: Oral Surgery ²	50%	50%	40%	60%
Extraction of impacted teeth				
Type III: Major Covered Services ² (after meeting deductible)	50%	50%	40%	60%
Prosthodontics - Bridges and Dentures				
General Anesthesia				
Crowns/Inlays/Onlays				
Type IV: Orthodontia				
Child	None	None	None	None
Adult	None	None	None	None
Lifetime Maximum	Not Applicable			
OON Reimbursement	MAC			
Provider Network	BlueDental PPO Network			
Roll-over Benefits	Not Included			

1. All per year benefits mean calendar year.
2. Plan determines that a less expensive alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition. The alternate treatment will produce a professionally satisfactory result; then the maximum the plan will allow will be the charge for the less expensive treatment.
3. Any combination of x-rays billed on the same date of treatment, cannot exceed the allowed amount for a full mouth x-ray benefit.
4. Please refer to Exclusion and Limitations for plan Details and coverage limitations.

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<u>In-Network Providers</u>	"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.
<u>Out-of-Network Providers</u>	"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.
<u>Optional Pre-determination</u>	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.
<u>Prevention Plus</u>	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 Limitations

1. Two evaluations per calendar year in any combination of periodic, limited, comprehensive, or problem focused.
2. Two prophylaxis (cleaning, scaling and polishing teeth) per calendar year.
 - a. One additional cleaning is covered during pregnancy and for diabetic patients (If applicable).
3. One topical fluoride per calendar year to age 16.
4. Bitewing x-rays, two per calendar year.
5. Periapical x-rays
6. One diagnostic x-ray, full or panoramic per 60 months
7. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service).
8. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars).
9. Simple extraction of teeth.
10. Composite and amalgam fillings per tooth per surface every 24 months (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)
11. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin).
12. Antibiotic injections administered by a dentist.
13. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).
14. 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 pericoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy.
 - f. Reimplantation or transplantation of a natural tooth.
 - g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
15. 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.
16. 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.

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| <ul style="list-style-type: none"> 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. |
| 17. One study model per 36 months. |
| 18. Crown build-up for non-vital teeth. |
| 19. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter. |
| 20. One repair of dentures or fixed bridgework per 24 months. |
| 21. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery, or implant placement procedures (if applicable). |
| 22. Restoration services, limited to: <ul style="list-style-type: none"> a. Cast metal, resin-based, gold or porcelain 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 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. |
| 23. Prosthetic services, limited to: <ul style="list-style-type: none"> a. Initial placement of removable dentures or fixed bridgework. 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. |
| 24. Teledentistry, synchronous (D9995) or asynchronous (D9996). Must be accompanied by a covered procedure |
| 25. Implants and related services (if applicable). |
| 26. Type IV. Orthodontia services.
Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy (if applicable). |

BCBSAZ Standard 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 (if applicable).
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony (except for D7880).
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
14. 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.
15. Treatment of cleft palate, malignancies or neoplasms.
16. Implants and related services (if applicable); replacement of lost, stolen, or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.