

## Exclusive Dental Coverage Benefits-at-a-Glance Plan 3

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

### In-Network

### Out-of-Network

#### Class I Services

Oral exams	Covered – 100%, twice per calendar year	Not covered
A set (up to 4) of bitewing X-rays	Covered – 100%, twice per calendar year	Not covered
Full-mouth and panoramic X-rays	Covered – 100%, once every 60 months	Not covered
Prophylaxis (teeth cleaning)	Covered – 100%, twice per calendar year	Not covered
Fluoride treatment	Covered – 100%, twice per calendar year	Not covered
Space maintainers – missing posterior (back) primary teeth	Covered – 100%, once per quadrant per lifetime, up to age 19	Not covered

#### Class II Services

Fillings – permanent teeth	Covered – 75%, once every 24 months	Not covered
Fillings – primary teeth	Covered – 75%, once every 12 months	Not covered
Onlays, crowns and veneer fillings – permanent teeth	Covered – 75%, once every 60 months, payable for members age 12 and older	Not covered
Recementing of crowns, veneers, onlays and bridges	Covered – 50%, three times per calendar year after six months from original restoration	Not covered
Oral surgery including extractions	Covered – 75%	Not covered
Root canal treatment – permanent tooth	Covered – 75%, once every 12 months for tooth with one or more canals	Not covered
Scaling and root planing	Covered – 75%, once every 24 months per quadrant	Not covered
Occlusal adjustments	Covered – 75%, up to five times in a 60-month period	Not covered
Occlusal biteguards	Covered – 75%, once every 12 months	Not covered
General anesthesia or IV sedation	Covered – 75%, when medically necessary and performed with oral or dental surgery	Not covered
Palliative (emergency) treatment	Covered – 75%	Not covered
Adjustment of dentures	Covered – 75%, six months or more after it is delivered	Not covered
Relining or rebasing of partials or complete dentures	Covered – 75%, once every 36 months per arch	Not covered
Tissue conditioning	Covered – 75%, once every 36 months per arch	Not covered
Repair and adjustments of partial or complete dentures	Covered – 75%	Not covered

#### Class III Services

Removable dentures (complete and partial)	Covered – 50%	Not covered
Bridges (fixed partial dentures)	Covered – 50%, once every 60 months after original was delivered	Not covered

#### Class IV Services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Covered – 50%	Not covered
Minor treatment to control harmful habits	Covered – 50%	Not covered
Interceptive and comprehensive orthodontic treatment	Covered – 50%	Not covered
Pos-treatment stabilization	Covered – 50%	Not covered
Cephalometric film (skull) and diagnostic photos	Covered – 50%	Not covered

#### Copays and Dollar Maximums

<b>Copays</b>	25% for class II services and 50% for class III and IV services	
<b>Dollar Maximums</b>		
• Annual Maximum	\$1,000 per member for class I, II and III services	Not applicable
• Lifetime Maximum	\$1,000 per member for class IV services	Not applicable

**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. **Services received outside the dental network are not covered.**