Blue Cross Blue Shield of Michigan 10-Day Money-Back Guarantee

Blue Cross Blue Shield of Michigan is committed to the health and satisfaction of our members. If for any reason you are unsatisfied and wish to terminate your coverage, simply notify BCBSM in writing within 10 days of the effective date of your coverage. You will receive a full refund of your premium. If you terminate your coverage after 10 days, you will receive a pro-rated refund on the unused portion of your premium. Please see the “How to Reach Us” section of this certificate for our mailing address and Customer Service telephone numbers.
This contract is between you and Blue Cross Blue Shield of Michigan. Because we are an independent corporation licensed by the Blue Cross and Blue Shield Association - an association of independent Blue Cross and Blue Shield plans - we are allowed to use the Blue Cross and Blue Shield names and service marks in the state of Michigan. However, we are not an agent of BCBSA and, by accepting this contract you agree that you made this contract based only on what you were told by BCBSM or its agents. Only BCBSM has an obligation to provide benefits under this certificate and no other obligations are created or implied by this language.
Dear Subscriber:

Your Blue Cross Blue Shield of Michigan (BCBSM) dental coverage is designed to help you and your eligible dependents maintain healthy smiles. And because dentists are often the first healthcare professionals to identify signs of serious health conditions in their patients, using your Blue DentalSM benefits could help you improve your overall health, too.

We encourage you to use your Blue Dental benefits. This certificate, along with any riders that amend it, will help you better understand these benefits. If you have questions about your coverage, please call us at 888-826-8152 or check our website at bcbsm.com.

This certificate, your signed application and your BCBSM identification card are your contract with us.

We’re pleased that you’re a Blue Dental subscriber, and we look forward to serving you for many years.

Sincerely,

Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan
About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- A Table of Contents — for quick reference
- Information About Your Contract
- What You Must Pay
- Coverage for Dental Services
- Dental Services Not Covered
- How Dental Benefits Are Paid
- General Conditions of Your Contract
- Definitions
- Additional Information You Need to Know
- How to Reach Us
- Index

This certificate provides you with the information you need to get the most from your dental care coverage.

If you have any questions please call customer service at: 888-826-8152. Business hours: Monday through Friday from 8 a.m. to 6 p.m. Eastern Time.

Please have your ID card with your group and contract numbers ready when you call us.

Your certificate refers to you as the subscriber because the contract is in your name.

The term patient refers to either you or one of your eligible dependents when you receive dental services. Your eligible dependents are those listed on your application.
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Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

- **ELIGIBILITY STANDALONE PLAN**
  - Who is Eligible to Receive Benefits
  - Changing Your Coverage
  - When You Can Enroll
  - When Your Benefits Begin

- **BILLING**
  - Information About Your Bill
  - How Rates are Classified

- **TERMINATION**
  - How to Terminate Your Coverage
  - How We Terminate Your Coverage
  - Rescission
ELIGIBILITY

Who is Eligible to Receive Benefits

Individuals who meet the following criteria are eligible to be enrolled in pediatric dental coverage:

- 18 years of age or younger on the plan’s effective date
- Are a resident of Michigan and a U.S. citizen or lawfully present in the United States and live in Michigan at least 180 days a year, except in the case of individuals living outside of Michigan temporarily (as in the case with college students).
- Are enrolled in a qualified health plan or medical plan

To get coverage, the parent, legal guardian or someone who is legally authorized to sign a contract on the child’s behalf, must complete an application. Individuals who are 18 years of age and applying for pediatric dental coverage for themselves, will be required to submit their own completed application.

The spouse or children of pediatric members are not covered under this certificate unless the pediatric member is the contract holder.

We will review the application to decide if the dependent child or child who is the contract holder is eligible for coverage. We will base our decision on the terms of the child’s benefit plan, which includes this certificate and any underwriting polices that are in effect at the time you apply.

If the pediatric member or someone applying for coverage on behalf of the pediatric member commits fraud or misrepresents material facts on purpose when filling out the application, this coverage may be rescinded. The section that explains “Rescission” is on page 9.

We will pay for services listed in this certificate or a Blue Dental rider only for members who are 18 years of age and younger on the date their coverage begins.

Children listed on your contract will receive pediatric dental benefits until the end of the calendar year in which they turn age 19 if:

- The children are related to you by:
  - Birth
  - Marriage
  - Legal adoption or
  - Legal guardianship

When a pediatric member no longer qualifies for benefits under this contract, that individual or his or her parent, legal guardian or other authorized person may apply for other dental coverage within 60 days of the date this coverage ends or during the annual open enrollment period.
Changing Your Coverage

You may change your coverage during the annual open enrollment period or at other times of the year as allowed by federal law.

You have the option to change who can receive benefits under your current coverage if there is a qualifying event, such as (but not limited to) a:

- Birth
- Adoption
- Marriage
- Divorce or
- Death of a member

If you purchased your coverage on the Health Insurance Marketplace (Marketplace), you must notify the Marketplace within 30 days of the change. You generally have up to 60 days after the event to make a new plan selection. The date of this change is set by federal law.

If your coverage was not purchased on the Marketplace, we must receive notice from you within 60 days of when a dependent or spouse is removed from coverage, and within 60 days of when a dependent or spouse is added. The date of the change and contract change effective dates are set by federal law. Not all effective dates are assigned the date of the event. The effective date depends on the type of event and options allowable by law.

If a pediatric member on your contract dies, please notify us, and your rate will be adjusted as of the date of death. You may not change your coverage until the next open enrollment period, except as established by federal law.

Once you receive your new ID card, do not use your old ID card. However, keep your old card until all claims under your prior dental policy or contract have been resolved.

When You Can Enroll

- During the annual open enrollment period
- Up to 60 days after a qualifying event as defined by federal law
- At other times of the year as allowed by federal law

When Your Benefits Begin

Covered benefits are available on the effective date of your contract.
Information About Your Bill

Each bill for a regular billing cycle covers a one-month period.

If you bought this coverage on the Health Insurance Marketplace (Marketplace) and the Marketplace determines you are eligible for a premium tax credit (subsidy):

- You are responsible only for your portion of the premium, not any applicable amount covered by the subsidy.

- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.

- You may get subsidies only if:
  - This coverage is available on the Marketplace and
  - You buy this coverage on the Marketplace

If you are receiving an advance payment of a federal premium tax credit and have paid at least one full month of premium during the current benefit year, you will be given a three-month grace period before we will terminate or cancel your coverage for not paying your premium when due. If you receive dental services at any time during the second and third months of the grace period, we will hold payment for claims for these services beginning on the first day of the second month of the grace period. We will notify your providers that we are not paying these claims during this time.

If we do not receive your payment in full for all premiums due before the grace period ends, your coverage will be terminated or cancelled. Your last day of coverage will be the last day of the first month of the three-month grace period. All claims for any dental services that were provided after that last day of coverage will be denied.

If you bought this coverage either off the Marketplace or on the Marketplace but are not eligible for a subsidy:

- You are responsible for the entire premium amount.

- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.
Billing (continued)

Information About Your Bill (continued)

- The three-month grace period does not apply if you do not receive a premium tax credit. If we do not receive your premium by the due date, we will allow you a grace period of 31 days, during which we will send you a final bill. If we do not receive your premium payment during the grace period, your coverage will be terminated or cancelled as of the last day of paid coverage.

   We will accept payment of your dental insurance premium only from you, your spouse, or when appropriate, from a parent, blood relative, legal guardian or other person or entity that is allowed by law to pay your premium on your behalf.

How Rates Are Classified

Your rate will be based upon certain rating factors such as age and where you live in accordance with federal law.

TERMINATION

How to Terminate Your Coverage

We will only accept termination of this coverage from the subscriber, the parent, guardian, or legal representative of the person(s) listed on this policy. Your coverage will be terminated and all benefits under this certificate will end.

If you voluntarily terminate your coverage and premium is due, BCBSM reserves the right to collect this premium from you. You may not be able to enroll in a dental product until the next annual open enrollment or unless you experience a qualifying event.

If you bought coverage under this certificate on the Marketplace, you may terminate it only if you contact the Marketplace with proper notice. The effective date of your request will be one of the dates described in Section 6, under “Termination of Coverage”.

If your coverage was not purchased on the Marketplace, call or send us your written request to terminate coverage at the phone number or address listed in Section 9, “How to Reach Us.” You may also call the phone number on your BCBSM identification card.

If you decide to terminate your coverage within 10 days after the date that it is effective, you will be given a full refund of the premium that you paid. If you decide to terminate your coverage after it has been effective for 10 days, you will be given a pro-rated refund of any excess premium.
How We Terminate Your Coverage

We will terminate this coverage if:

- A pediatric member is no longer eligible for coverage under this certificate.
  
  In this situation, only the ineligible pediatric member’s coverage will be terminated. Coverage for eligible pediatric members that may also be on this contract will remain active.

- You do not pay your bill on time.

- The individual who arranged for the pediatric member’s coverage under this certificate is serving a criminal sentence for defrauding BCBSM.

- You cannot provide proof you live in Michigan at least 180 days a year, except for individuals living outside of Michigan temporarily (as in the case with college students).

- We no longer offer this coverage.

- **You misuse your coverage.**

  Misuse includes illegal or improper use of your coverage such as:
  
  - Allowing another person to use this coverage
  - Requesting payment for services that were not received

- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your right to appeal.

- The individual who arranged for the pediatric member’s coverage under this certificate is satisfying a civil judgment in a case involving BCBSM.

- The individual who arranged for the pediatric member’s coverage under this certificate is repaying BCBSM funds he/she received illegally

Your coverage will end on the last day covered by your last premium payment. If a pediatric member is no longer eligible for coverage because of age, coverage will end on the last day of the calendar year in which the pediatric member turns age 19.

If we terminate or cancel your coverage, we will provide you with 30 days’ notice, along with the reason for the termination or cancellation.
Section 1: Information About Your Contract

Rescission

We will rescind coverage if the pediatric member or someone seeking coverage on the pediatric member’s behalf has:

- Performed an act, practice or omission that constitutes fraud, or

- Made an intentional misrepresentation of material fact to BCBSM or another party, which results in obtaining or retaining this coverage with BCBSM or the payment of claims under this or another BCBSM certificate.

We may rescind your coverage back to the effective date of your contract. If we do, we will provide the subscriber, parent, guardian, or legal representative with 30 days’ notice. The subscriber or his/her parent, guardian, or legal representative must repay BCBSM for its payment for any services received during this period.
Section 2: What You Must Pay

You may have to pay a deductible and/or coinsurance for covered dental services. A rider that amends this certificate will explain what cost-sharing you must pay.

**Deductible Requirements**

The deductible (if any) is the amount you must pay for covered services each calendar year before we pay for services. The rider that amends this certificate will tell you if you have a deductible or a family limit on your deductible and how much it will be.

We will not apply payments toward your deductible if one of the following applies:

- The payment is for a charge that exceeds our approved amount.
- The payment is for noncovered services.

**Coinsurance Requirements**

The coinsurance is the portion of the approved amount that you are required to pay for covered services. A rider will indicate your coinsurances.

We will not apply a coinsurance to:

- The difference between our approved amount or approved PPO fee and the dentist’s charge
- Non-covered services

**Annual Benefit Maximum**

Your annual benefit maximum will be determined by your benefit rider(s).

**Out-Of-Pocket Maximum**

This is the maximum out-of-pocket costs you will pay in a calendar year for deductible and coinsurances required for most covered dental services provided by PPO (in-network) dentists. Only covered services provided by PPO dentists will apply to the out-of-pocket maximum. After you reach the out-of-pocket maximum, you will not pay any more deductibles or coinsurances for in-network services for the remainder of the calendar year.

We will not apply payments toward your out-of-pocket maximum that:

- Are for services provided by non-PPO dentists
- Exceed our approved PPO fee
- Are for noncovered services
Out of Pocket Maximum (continued)

- Are for orthodontic services

Only payments toward your cost-share are applied toward your out-of-pocket maximum. This means that if you receive services from a nonparticipating provider and you are required to pay that provider directly for those services, those charges will not apply to your out-of-pocket maximum.
Section 3: Coverage for Dental Services

This section describes the services we pay for and the extent to which they are covered.

- We pay for services when they are provided according to this certificate and any riders that amend it. To be covered, services must be:
  - Dentally necessary, and
  - Performed by a dentist, or where applicable
  - Performed by a dental hygienist under the supervision of a dentist

See Section 4, “Dental Services Not Covered”, for applicable exclusions and limitations.

CLASS I

- Diagnostic and preventive services
- Oral brush biopsy sample collection

CLASS II

- Other diagnostic and preventive services
- Emergency palliative treatment
- Minor restorative services
- Prosthodontic services
- Adjunctive general services
- Endodontic services
- Periodontic services
- Oral surgery services

CLASS III

- Other endodontic services
- Other periodontic services
- Major restorative services
- Other oral surgery services
- Other prosthodontic services
Class I

- **Diagnostic and preventive services** – to set a baseline for a patient’s oral health. They evaluate or re-evaluate existing conditions. They prevent oral disease and they stop the progress of disease already present. These services include:
  - Oral examinations/evaluations
  - Prophylaxis
  - Fluoride treatments

- **Topical fluoride varnish**

- **Radiographs** (X-rays – as needed for routine care or to diagnose a specific condition.
  - (X-rays) of the mouth, teeth, jaw, skull and facial bones
  - Bitewings: One set (up to four) of bitewing X-rays once per calendar year
  - Individual periapical films: Covered (up to six) per calendar year

- **Oral brush biopsy sample collection** – to detect cancerous and precancerous cells

Class II

- **Other diagnostic and preventive services**
  - Diagnostic tests and laboratory examinations
  - Dental Sealants
  - Space maintainers

- **Radiographs** (X-rays) of the mouth, teeth, jaw, skull and facial bones
  - Full-mouth series - The series includes bitewings and periapical films taken on the same day
  - Panoramic X-rays - Panoramic X-rays with or without bitewings taken on the same day, are considered full-mouth X-rays

- **Emergency palliative treatment** – for temporary pain relief

- **Minor restorative services** – to repair decayed or damaged teeth. These services include:
  - Amalgam and resin-based composite fillings and fillings of similar materials
  - Recementation or repair of posts, crowns, veneers, inlays and onlays

- **Oral surgery services** – for simple extractions
Class II (continued)

- **Endodontic services** – to treat teeth with diseased or damaged nerves. These services include:
  - Root canal treatments on permanent teeth and on primary teeth without permanent successors
  - Therapeutic pulpotomies or pulpal debridement
  - Vital pulpotomies on primary teeth

- **Periodontic services** – to treat diseases of the gums and the structures that support the teeth. These services include:
  - Periodontal maintenance following periodontal scaling and root planing or surgical periodontal treatment

- **Adjunctive general services** – in connection with dental care. These services include:
  - General anesthesia or IV sedation in connection with oral surgery, when medically or dentally necessary as determined by BCBSM
  - Office visits for observation (during regularly scheduled hours)

- **Prosthodontic services** – to repair or replace missing or deficient natural teeth or tissue. These services include:
  - Adjustments, repairs, relines, rebases and tissue conditioning for prosthodontic appliances
  - Recementation of fixed bridges

*Class III*

- **Major restorative services** – to repair decayed or damaged teeth. These services include:
  - Onlays, crowns and veneers, but only when a tooth cannot be restored with materials such as amalgam or resin-based composite fillings
  - Substructures, including cores with or without pins and posts with cores or pins

- **Other oral surgery services**
  - Surgical and impacted tooth extractions and root removal
  - Surgical exposure and facilitation of eruption of unerupted teeth
  - Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue
  - Removal of exostoses (excess bony growths of the upper and lower jaw)
  - Excision of hyperplastic tissue per arch
  - Frenulectomies
Class III (continued)

- **Other endodontic services** – to treat teeth with diseased or damaged nerves. These services include:
  - Apical surgeries on permanent teeth
  - Hemisection

- **Other periodontic services** – to treat diseases of the gums and the structures that support the teeth. These services include:
  - Gingivectomies and gingivoplasties
  - Gingival flap procedures
  - Soft tissue grafts
  - Periodontal scaling and root planing

- **Other prosthodontic services** – to repair or replace missing or deficient natural teeth or tissue. These services include:
  - Complete dentures
  - Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics
  - Repairs of fixed partial dentures (bridges)
  - Stayplates to replace recently extracted permanent anterior (front) teeth
Section 4: Dental Services Not Covered

The services listed in this section are in addition to all other services that we do not cover which are stated in this certificate.

Exclusions

The following services are not covered under this certificate unless you have a rider that adds coverage for them. You are responsible for paying the charges for these services:

- Services that are covered under medical or drug plans. These services include hospital, medical and prescription drug benefits. Any surgery that is usually covered under a medical plan is not covered under this certificate.

- Facility or hospital fees that a dentist, physician or hospital charges for treating a patient in the hospital.

- Services to correct birth defects or developmental defects, such as cleft palate and jaw deformities.

- Services performed solely for cosmetic reasons (e.g., teeth bleaching, bonding or veneers when there is no decay or fracture).

- Personalized or customized services.

- Services that are not needed to diagnose or treat a dental condition or that were not recommended and approved by the attending dentist.

- Services to treat injuries to the mouth or jaw as a result of an accident.

- Charges for missed appointments.

- Charges for completing claim forms and other charts or reports.

- Charges for instruction in oral hygiene, diet or plaque control programs.

- Services provided by anyone other than a dentist; however, we will cover services of a dental hygienist when he or she works under the supervision of a dentist and the hygienist is licensed to perform the services.

- Office visits for observation during regulatory scheduled hours when any other treatment is provided at that same visit.

- House and hospital calls.
Section 4: Dental Services Not Covered

Exclusions (continued)

- Drugs that are:
  - Prescribed by your dentist
  - Available without a prescription
  - Not dispensed by your dentist
  - Injected
  - Used in connection with non-covered services
  - Used for antibiotic prophylactic or behavior management purposes

- Oral medications, topically applied antibiotics and non-antibiotic injections.

- Local anesthetic or analgesic billed as a separate service.

- Desensitizing medications.

- Supplies and barrier techniques used for infection control.

- Rubber dams.

- Consultations by dentists who are not treating the member unless the treating dentist requests the consultation and it relates to a covered treatment.

- Pulp tests performed at the same visit as:
  - An oral examination or evaluation
  - A restorative, endodontic, periodontic or prosthodontic service

- Space maintainers for missing (front primary teeth or provided in connection with orthodontic treatment.

- Recementing a space maintainer, post, crown, veneer, inlay, onlay or bridge within six months of its initial placement.

- Repair or replace lost, missing, or stolen restorations, appliances or prosthetics of any type.

- Repair of space maintainers or orthodontic appliances.

- Duplicate X-rays used for administrative or other purposes.

- Sialography.

- Biopsies performed on the same date as any other service.

- Bacteriology studies to determine oral health status or pathological agents.
Exclusions (continued)

- Histopathological examinations.

- Mounted case analyses.

- Emergency palliative treatment when any other treatment is provided on the same date (except for limited X-rays needed to diagnose the emergency condition).

- Charges for diagnostic tests that are paid as part of the total fee for:
  - An oral examination or evaluation, or
  - A restorative, endodontic, periodontal, surgical or prosthodontic service

- Charges for services related to restorations that are paid as part of the total fee for the restoration; these services include (but are not limited to):
  - Etchings
  - Bases
  - Liners
  - Temporary fillings
  - Local anesthesia
  - Preparative and other supplies

- Charges for services that are paid as part of the total fee for any other service.

- Restorations to stabilize teeth, change the occlusion, correct the vertical dimension, strengthen a tooth, prevent a future problem or close a space.

- Restorations to adjust or restore missing tooth structure due to abrasion, attrition or erosion.

- Inlays, except under very limited circumstances with individual consideration by report.

- Veneer facings or other facings on crowns or pontics, except on tooth numbers 4-13 and 20-29 (the central and lateral incisors, cuspids and first and second bicuspids).

- Prophylaxes or periodontal maintenance within 60 days of periodontal scaling and root planing or periodontal surgery.

- Prophylaxes in conjunction with scaling and root planing, except one quadrant with individual consideration by report.

- Periodontal surgical barriers and guided tissue regeneration.

- Localized delivery of anti-microbial agents.

- Bone replacement grafts.
Section 4: Dental Services Not Covered

Exclusions (continued)

- Occlusal adjustments.
- Occlusal biteguards.
- Limited occlusal adjustments for pediatric members.
- Osseous surgery.
- Repairs or adjustments of bridges, removable partial dentures or removable complete dentures within six months of their initial delivery; relines or rebases of removable partial or complete dentures within six months of their initial delivery.
- General anesthesia or IV sedation, unless medically or dentally necessary.
- Onlays, crowns and veneers on primary teeth, except with individual consideration by report when there is adequate root structure and no permanent successor.
- Sargenti root canal treatment.
- Temporary crowns for fracture of permanent teeth, except with individual consideration by report.
- Temporary fixed partial dentures on other than anterior permanent teeth.
- Temporary dentures.
- Coping as a definitive restoration, except with individual consideration by report.
- Periodontal splinting of any type.
- Precision attachments and cores or retainer bars for overdentures.
- Root canals for overdentures.
- Fitting a crown to a partial denture clasp.
- Functional or myofunctional therapy.
- Dental implants and related services, including abutment placement and repair and maintenance of implants and surrounding tissues.
- Services for the diagnosis or treatment of temporomandibular joint dysfunction (TMJ).
- Orthodontia and related services.
Exclusions (continued)

- Services by a student at a dental or medical school that is outside of Michigan.
- The more costly treatment when two or more methods are available to treat a condition. We will pay the approved amount, less the required coinsurance and deductible (if any) for the least costly acceptable treatment.
- Services or devices that are personal use or for use at home, such as mouth trays and electric toothbrushes.
- Transportation or travel, even if prescribed by a dentist.
- Any services, devices or charges not listed in this certificate as payable.

Limitations

The limitations on covered dental services are described below. They apply unless you have a rider that amends this certificate that says otherwise. We will pay for:

- Routine oral examinations and evaluations – twice every calendar year.
- A set (up to four) of bitewing X-rays – once every calendar year.
- A full-mouth series of X-rays (including bitewing and periapical X-rays taken on the same day) – once every 60 months – Panoramic X-rays are considered full-mouth X-rays.
- Pulp tests – once every visit, regardless of the number of teeth evaluated.
- Diagnostic casts – once every 60 months per dentist.
- Fluoride treatments or topical fluoride varnishes – twice every calendar year.
  - For moderate to high-risk patients age 3 and younger – two additional topical fluoride varnishes every calendar year.
- Dental sealants – once per tooth every 36 months for first and second permanent molars.
- Space maintainers – once per quadrant per lifetime for missing posterior (back) primary teeth. Space maintainers are covered only for pediatric members age 16 and younger.
  - Recementing a space maintainer – three times per quadrant per lifetime.
- Oral brush biopsy sample collection – twice every calendar year.
Section 4: Dental Services Not Covered

Limitations (continued)

- Replacement fillings for permanent teeth – once per tooth and surface every 48 months.
- Stainless steel crowns – once per tooth every calendar year.
- Root canal treatment for a tooth involving one or more canals – once per tooth per lifetime.
- Recementing the following items – three times per tooth six months or more following initial placement:
  - Posts
  - Crowns
  - Veneers
  - Inlays
  - Onlays
  - Fixed partial dentures (bridges)
- Recementation of fixed partial bridges – once per 60 months six months or more following initial placement.
- Retreatment of a root canal 12 or more months after the initial root canal treatment – once per tooth per lifetime.
- Hemisection, not including root canal for permanent teeth, once per tooth per lifetime.
- Periodontal maintenance – three times every calendar year in combination with routine dental exam and cleaning.
  - We will pay for a prophylaxis prior to periodontal scaling and root planing or periodontic surgical services.
- Periodontal scaling and root planing – once every 24 months per quadrant.
- Periodontic surgical services – once every 36 months per quadrant.
- Relines or rebases of removable partial or complete dentures – once per arch every 36 months.
- Tissue conditioning – once per arch every 36 months, six months or more following initial placement.
- Onlays, crowns and veneers – once per permanent tooth every 84 months when a tooth cannot be restored with another filling material; we will pay for these services only for members age 12 and older.
Section 4: Dental Services Not Covered

Limitations (continued)

- Substructures – once per permanent tooth every 60 months with a limit of one substructure type per tooth; we will pay for substructures only for members age 12 and older.
- Complete dentures – once every 84 months.
- Bridges and removable partial dentures – once every 84 months for members age 16 and older.
Section 5: How Dental Benefits Are Paid

Choosing A Dentist
You may choose any dentist. However, your out-of-pocket cost is less when you select a Blue Dental PPO (in-network) dentist.

Our payment will vary based on whether your dentist is a:

- **PPO dentist** – Agrees to accept our PPO fee for services.

- **Participating Dentist** – Non-PPO dentist who participates with us on a per-claim basis and agrees to accept our approved amounts for services.

- **Nonparticipating Dentist** – Non-PPO dentist who does not participate with us on a per-claim basis and has not agreed to accept our approved amounts for services. A nonparticipating dentist may bill you for the difference between what we paid you for covered services and the amount the dentist charges.

You should always ask whether your dentist is a Blue Dental PPO dentist or if he or she agrees to participate with us for every service provided.

If you choose to get services from a non-PPO dentist who will not participate with us for these services, you will have to pay the difference (if there is any) between what we pay and what the dentist charges.

Please see the subsection titled, “Paying For Services” in this section for more information about how we pay your dental claims.

Predetermination of Benefits
Your dentist may, but is not required to, submit his or her treatment plan to us for predetermination before providing you with certain complex or expensive services. We will review the plan **before** the services are performed and let you and your dentist know whether the planned services will be covered and how much we will pay for them.

If we determine that an alternative course of treatment will produce acceptable results at a lower cost, the most we will pay is our approved amount for the treatment we recommend. If you and your dentist choose the treatment plan that was submitted by your dentist, you can apply the amount we approve for the recommended alternative to the original plan. However, you will be responsible for any difference in cost.

Predetermination is **not** a guarantee of payment. Our payment for these services is based on the benefits that are available to you when the services are actually provided, and on the requirements of this certificate.

An approved predetermination is valid for 24 months. If the services have not been completed within that time, you can ask for a new predetermination.
Predetermining Benefits (continued)

If you receive services that require predetermination from a provider who does not participate with us, and the provider does not get the predetermination before those services are received, you will have to pay the bill yourself. We will not pay for it. It is important to make sure that the nonparticipating provider gets that predetermination before you receive the services.

Filing Claims
You or your dentist must file a claim for benefits in the form we require within 24 months of the date services were completed before we will pay for covered services. The dentist must certify that services were provided as billed. We have the right to deny payment for services if we have not received a claim for those services within 24 months of the date they were completed.

For some procedures, we require documentation such as:

- X-rays, models of the teeth and jaw or
- A written explanation as to why the procedures were needed. A BCBSM dental consultant reviews this documentation to determine dental necessity.

Paying For Services
We pay for covered dental services performed inside and outside the state of Michigan. Below is a description of how we pay for covered services.

- **PPO (In-Network) Dentist:**
  Blue Dental PPO dentists agree to accept our approved amount as payment in full for covered services. In most cases, our approved amounts for PPO dentists are lower than our approved amounts for non-PPO dentists, so the coinsurance amount you are responsible for will also be lower. We pay PPO dentists directly. You are responsible for your deductible and/or coinsurance, as well as any charges for non-covered services.

- **Non-PPO (Out-of-Network) Dentist**
  Non-PPO dentists may (but are not required to) participate with BCBSM on a per-claim basis through our Blue Par Select arrangement:

  - **Participating Dentist**
    - A non-PPO dentist can participate on a claim by indicating on the claim form that we should pay him or her directly for covered services. By cashing our check, the dentist enters into a contract with us and agrees to accept our approved amount as payment in full for covered services.
    - You must pay your deductible and/or coinsurance, as well as any charges for non-covered services.
    - You should always ask whether your dentist is going to participate with us for every service he or she provides. If your dentist indicates that he or she will not participate with us for a particular service and you still choose to have him or her provide that service, you are responsible for any costs that exceed our reimbursement.
Non-PPO (Out-of-Network) Dentists (continued)

- **Nonparticipating Dentist**

  - If a non-PPO dentist chooses not to participate on a claim, we will pay you directly for covered services. Our payment will be the lesser of the amount billed or our approved amount. You are responsible for the entire amount billed by your dentist, which may be higher than our approved amount.

The dentist may also bill for services completed by a hygienist working under his or her supervision.

**Understanding Our Payment—Your Explanation of Benefits**

After your claim is processed, we will send you an Explanation of Benefits that provides the following information:

- The names of the dentist and the patient
- A description of each service submitted on that claim
- The dates these services were provided
- The amounts the dentist charged for them and the amounts we allowed and paid for them
- What you saved by going to a participating dentist
- Any deductible and coinsurance you must pay
- What you may owe

If we denied payment for any of the services that were submitted, your EOB will explain why the services were denied.

Please call us if you have questions regarding payments shown on your EOB.
Section 6: General Conditions of Your Contract

This section explains the conditions that apply to your certificate. They may make a difference in how, where and when benefits are available to you.

Assignment
Benefits covered under this certificate are for your use only. They cannot be transferred or assigned. Any attempt to assign them will automatically terminate all your rights under this certificate. You cannot assign your right to any payment from us, or for any claim or cause of action against us, to any person, provider, or other insurance company.

We will not pay a provider except under the terms of this certificate.

Changes in Your Family
We must be notified within 30 days of any changes in your family. This requires you to complete an Enrollment/Change of Status form.

If you purchased your coverage on the Health Insurance Marketplace (Marketplace), you must notify the Marketplace within 60 days of the change. When the Marketplace notifies BCBSM, the change will take effect. The date of this change is set by federal law.

If your coverage was not purchased on the Marketplace, we must receive notice from you within 60 days of when a dependent or spouse is removed from coverage, and within 60 days of when a dependent or spouse is added. Contract changes take effect as of the date of the event.

Changes include marriage, divorce, birth, death, adoption, or the start of military service. An Enrollment/Change of Status form should be completed when you have a change of address.

Changes to Your Certificate
BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.

- Any changes must be approved by BCBSM and the Michigan Department of Insurance and Financial Services.
- We may add, limit, delete or clarify benefits in a rider that amends this certificate. If you have riders, keep them with this certificate.

Coordination of Benefits
We will coordinate benefits payable under this certificate per Michigan’s Coordination of Benefits Act.

Deductibles, Copayments and Coinsurances Paid under Other Certificates
We do not pay any cost-sharing that you must pay under any other certificate. The exception is when we must pay them under coordination of benefits requirements.
Dentist of Choice
You may continue to receive services from the dentist of your choice. However, if you receive services from a non-PPO (out-of-network) dentist, you may incur additional costs.

Enforceability of Various Provisions
Failure of BCBSM to enforce any of the provisions contained in this contract will not be considered a waiver of those provisions.

Entire Contract; Changes
This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Experimental or Investigational Services
We do not pay for a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient’s condition. BCBSM decides if something is experimental based on one or more of the following:

- Information from the American Dental Association and other appropriate professional organizations
- Information from the Food and Drug Administration and other government agencies
- Accepted national standards of practice in the dental profession
- Scientific data such as controlled studies in peer review journals or literature
- Information from the Blue Cross and Blue Shield Association or other local or national bodies

Fraud, Waste and Abuse
We do not pay for the following:

- Services that are not dentally necessary; may cause significant patient harm; or are not appropriate for the patient’s documented dental condition;
- Services that are performed by a provider who is sanctioned at the time the service is performed

Sanctioned providers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

BCBSM will notify you if any provider you have received services from during the previous 12 months has been sanctioned. You will have 30 days from the date you are notified to submit claims for services you received prior to the provider being sanctioned. After that 30 days has passed, we will not process claims from that provider.
**Genetic Testing**

We will not:

- Adjust premiums for this coverage based on genetic information related to you, your spouse or your dependents
- Request or require genetic testing of anyone covered under this certificate
- Collect genetic information from anyone covered under this certificate at any time for underwriting purposes
- Limit coverage based on genetic information related to you, your spouse or your dependents

**Grace Period**

A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

**Improper Use of Contract**

If you let any ineligible person receive benefits (or try to receive benefits) under this certificate, we may:

- Refuse to pay benefits
- Terminate or cancel your coverage
- Begin legal action against you
- Refuse to cover your health care services at a later date

**Notification**

When we need to send you a notice, we mail it your employer or remitting agent or to your most recent address we have in our records, as applicable. This fulfills our obligation to notify you.

**Personal Costs**

We will not pay for:

- Transportation and travel, even if prescribed by a dentist
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

**Refunds of Premium**

If we determine that we must refund a premium, we will refund up to a maximum of two years of payments.
Section 6: General Conditions of Your Contract

Release of Information
You agree to let providers release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications
If we tell you a member is eligible for coverage or benefits are available, this does not guarantee your claims will be paid. Claims are paid only after:

- The reported diagnosis is reviewed
- Dental necessity is verified
- Benefits are available when the claim is processed

Right to Interpret Contract
During claims processing and internal grievances, BCBSM has the right to make clear and administer the terms of this certificate and any riders that amend it. You may appeal BCBSM's final adverse decisions about claims processing and grievances under the law.

Services Before Coverage Begins and After Coverage Ends
We will not pay for any services, treatment, care or supplies provided:

- Before the effective date of this certificate
- After the date on which coverage under this certificate ends

After coverage ends, we will pay for crowns, bridges, inlays (if applicable), onlays, veneers or dentures, as described in Section 3, under the following conditions:

- They are ordered or final impressions have been completed before your coverage ends.
- The procedure is completed or the appliance is delivered within 60 days from the date the coverage ended.

*NOTE* We will not pay for any orthodontic treatment rendered prior to the effective date of your dental coverage.
Services That are Not Payable
We do not pay for services that:

- You legally do not have to pay for or for which you would not have been charged if you did not have coverage under this certificate
- Are available in a hospital maintained by the state or federal government, unless payment is required by law.
- Can be paid by government-sponsored health care programs, such as Medicare, for which a member is eligible. We do not pay for these services even if you have not signed up to receive the benefits from these programs. However, we will pay for services if federal laws require the government-sponsored program to be secondary to this coverage.
- Are more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results
- Are not listed in this certificate as being payable

Subrogation: When Others are Responsible for Illness or Injury
If BCBSM paid claims for an illness or injury, and:

- Another person caused the illness or injury, or
- You are entitled to receive money for the illness or injury

Then BCBSM is entitled to recover the amount of benefits it paid on your behalf.

Subrogation is BCBSM’s right of recovery. BCBSM is entitled to its right of recovery even if you are not “made whole” for all of your damages in the money you receive. BCBSM’s right of recovery is not subject to reduction of attorney’s fees, costs, or other state law doctrines such as common fund.

Whether you are represented by an attorney or not, this provision applies to:

- You
- Your covered dependents

You agree to:

- Cooperate and do what is reasonably necessary to assist BCBSM in the pursuit of its right of recovery
- Not take action that may prejudice BCBSM’s right of recovery
- Permit BCBSM to initiate recovery on your behalf if you do not seek recovery for illness or injury
Subrogation: When Others are Responsible for Illness or Injury (continued)

- Contact BCBSM promptly if you:
  - Seek damages
  - File a lawsuit
  - File an insurance claim or demand or
  - Initiate any other type of collection for your illness or injury

BCBSM may:

- Seek first priority lien on proceeds of your claim in order to fulfill BCBSM’s right of recovery
- Request you to sign a reimbursement agreement
- Delay the processing of your claims until you provide a signed copy of the reimbursement agreement
- Offset future benefits to enforce BCBSM’s right of recovery

BCBSM will:

- Pay the costs of any covered services you receive that are in excess of any recoveries made

_Examples where BCBSM may utilize the subrogation rule are listed below._

- BCBSM can recover money it paid on your behalf if another person or insurance company is responsible:
  - When a third party injures you, for example, through medical malpractice
  - When you are injured on premises owned by a third party
  - When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to medical reimbursement coverage

Termination of Coverage (If you purchased this coverage ON the marketplace)

If you purchased this coverage on the Health Insurance Marketplace (Marketplace), you must notify the Marketplace if you want to terminate your coverage under this certificate. Once you provide this notice, the Marketplace will notify us of the date the termination takes effect, which is usually 14 days from the date of notification.

If we decide to terminate your coverage under this certificate, we will notify you of our decision at least 30 days before your last day of coverage. The notification will include the reason for the termination and the date your coverage will end.

**NOTE**: We will not terminate your coverage for any reason other than those listed on pages 8 and 9 of this certificate.
Termination of Coverage (If you purchased this coverage OFF the marketplace)
If your coverage was not purchased on the Marketplace, call or send us your written request to terminate coverage at the phone number or address listed in Section 9, “How to Reach Us.” You may also call the phone number on your BCBSM identification card. We will terminate your coverage on the current date or future date you provide us.

If we decide to terminate your coverage under this certificate, we will notify you of our decision at least 30 days before your last day of coverage. The notification will include the reason for the termination and the date your coverage will end.

We will not terminate your coverage for any reason other than those listed on pages 8 and 9 of this certificate.

Time Limit for Filing Claims
We will not pay for claims for services that are not filed within two years from the date of services.

Time Limit for Legal Action
You may not begin legal action against us later than three years after the date of service of your claim. If you are bringing legal action about more than one claim, this time limit runs independently for each claim.

You must first exhaust the grievance and appeals procedures, as explained in this certificate, before you begin law action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable.

Unlicensed and Unauthorized Providers
We do not pay services provided by persons who are not:

- Appropriately credentialed or privileged (as determined by BCBSM), or
- Legally authorized or licensed to order or provide such services.

What Laws Apply
This certificate will be interpreted under the laws of the state of Michigan and federal law where applicable.

Workers Compensation
We do not pay for treatment of work-related injuries covered by workers compensation laws. We do not pay for work-related services you get at an employer’s medical clinic or other facility.
Section 7: Definitions

This section explains the terms used in your certificate.

**Abutment**
A connection to the implant that offers retention, support and stabilization of the false replacement tooth.

**Accidental Injury**
An external force to the lower half of the face or jaw that damages or breaks sound natural teeth, periodontal structures or bone.

**Adverse Benefit Decision**
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate or cancel coverage.

**Amount Billed**
The dollar amount that the dentist reports to BCBSM on a dental claim, less any amount that the dentist may discount, waive, rebate or has not, in good faith, attempted to collect.

**Approved Amount**
The lower of the amount billed or the BCBSM maximum payment level for a covered service. Coinsurances or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

**BCBSM**
Blue Cross Blue Shield of Michigan.

**By Report**
A written explanation from the dentist that justifies the need for a procedure.

**Calendar Year**
A period of time beginning January 1 and ending December 31 of the same year.

**Cancellation**
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

**Certificate**
This book, which describes your benefit plan, and any riders that amend it.

**Claim for Damages**
A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.
Section 7: Definitions

Coinsurance
A portion of the approved amount that you must pay for a covered service. This amount is determined based on the approved amount at the time the claims are processed. Your coinsurance is not altered by an audit, adjustment or recovery.

Contract
Your BCBSM contract includes:

- This certificate
- Any related riders
- Your signed application for coverage
- Your BCBSM ID card

Copayment
The dollar amount that you must pay for a covered service. Your copayment is not altered by any audit, adjustment or recovery.

Cost–sharing
Copayments, coinsurances, and deductibles you must pay under this certificate.

Course of Treatment
A planned program of services for the treatment of a dental condition diagnosed by a dentist as the result of an oral examination/evaluation. A course of treatment begins on the date a dentist first provides a service to treat the dental condition.

Covered Services
The services, treatments or supplies listed in your certificate that are eligible for be paid by us.

To be paid by BCBSM, covered services must be:

- Dentally necessary, as defined in this section
- Ordered or performed by a provider that is:
  - Legally authorized or licensed to order or perform the service and
  - Determined by BCSSM to be appropriately credentialed or privileged to order or perform the service

Deductible
The amount that you must pay for covered services, under any certificate or rider, before benefits are payable. Payments made toward your deductible are based on the approved amount at the time of the claims are processed. Your deductible is not altered by an audit, adjustment, or recovery.
Dentally Necessary
A service or device must be dentally necessary and appropriate according to generally accepted standards and patterns of dental practice for it to be covered by BCBSM. Dentists acting for BCBSM decide dental necessity. It is based on criteria and guidelines developed by these dentists who are acting for their respective peer provider type or specialty.

The covered service is accepted as necessary and appropriate for the patient’s condition. It is not mainly for the convenience of the member or dentist.

- Covered services are subject to certain restrictions based on:
  - Policies consistent with generally accepted standards of dental practice
  - Those specific contracts that only pay for the least expensive acceptable treatment

- In the case of diagnostic testing, the results are essential to and are used in diagnosis or management of the patient’s condition.

  When there are no established criteria, dental need will be decided by the accepted standards and practices by the dentists who are providing services for BCBSM members.

Dental Services
Services for diagnosis, prevention or treatment in connection with the care, restoration, filling, removal or replacement of teeth or the structures directly supporting the teeth

Dentist

- **PPO (In-network) Dentist**
  A dentist who has signed a contract to participate in the Preferred Provider Organization (PPO) network used by BCBSM. PPO dentists agree to accept our approved amount as full payment for covered services.

- **Non-PPO (Out-of-network) Dentist**
  A dentist who has not signed a contract to participate in the Preferred Provider Organization (PPO) network used by BCBSM. Non-PPO dentists may (but are not required to) participate with BCBSM on a per-claim basis.
    - **Participating Dentist**
      A non-PPO dentist who participates on a Blue Dental claim and receives payment directly from BCBSM. Participating dentists agree to accept our approved amount as full payment for covered services.
    - **Nonparticipating Dentist**
      A non-PPO dentist who does not participate on a Blue Dental claim and receive payment directly from BCBSM. Nonparticipating dentists do not agree to accept our approved amount as full payment for covered services.

Department of Insurance and Financial Services (DIFS)
The department that regulates insurers in the state of Michigan.
Section 7: Definitions

Effective Date
The date your coverage begins under this contract. This date is established by BCBSM.

Endosteal Implant
A device specifically designed to be placed surgically in either the upper or lower jaw where the tooth is missing, therefore eliminating the need to attach the false tooth to adjacent teeth in the mouth. Instead the false tooth is attached directly to the endosteal implant structure that is embedded in bone.

Exclusions
Situations, conditions or services that are not covered by the subscriber's contract.

First Priority Security Interest
The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff’s recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Hygienist
A person who is licensed to perform specific dental procedures under the supervision of a licensed dentist. The procedures include, but are not limited to:

- Scaling
- Root planing
- Prophylaxis (teeth cleaning)
- Fluoride

Lien
A first priority security interest in any money or any action to recover money for the treatment of injuries for which we paid benefits.
Section 7: Definitions

**Member**
Any person eligible for dental care services under this certificate on the date the services are provided. This means the subscriber and any eligible dependents listed on the application. The member is the "patient" when receiving covered services.

**Myofunctional**
Relating to muscle function, especially in the treatment of orthodontic problems.

**Nonparticipating Dentist**
See the definition of “Dentist”.

**Non-PPO (Out-of-Network) Dentist**
See the definition of “Dentist”.

**Ordered**
When the dentist has completed preparing the mouth for an inlay, onlay, crown, bridge or denture and has taken final impressions for the laboratory.

**Participating Dentist**
See the definition of “Dentist”.

**Patient**
The subscriber or eligible dependent who is awaiting or receiving dental care and treatment.

**Pediatric Member**
Members who are age 18 or younger when their coverage begins are considered pediatric members until the end of the calendar year in which they turn age 19.

**Plaintiff**
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

**Post-service grievance**
A post-service grievance is an appeal that you file when you disagree with our payment decision or our denial for a service that you have already received.

**PPO (In-Network) Dentist**
See the definition of “Dentist”.

**PPO Fee**
BCBSM’s maximum payment level for a covered service provided by a PPO dentist. This amount may be different from the maximum payment level for a covered service provided by a non-PPO dentist.

**Predetermination**
A process by which a dentist submits a treatment plan to us before treatment begins. We return a copy of the proposed treatment plan to the dentist indicating covered services under the terms of your contract or available alternative treatments as determined by BCBSM.
**Pre-service grievance**
A pre-service grievance is an appeal that you can file when you disagree with our decision not to pre-approve a service you have not yet received.

**Provider**
A dentist or hygienist who provides services or supplies related to dental care.

**Quadrant**
Dental arches are divided into equal sections known as quadrants. A quadrant begins at the mid-line (center teeth) of the arch and extends back to the end of the upper or lower jaw.

**Qualifying Event**
One of the following events that allows you to enroll in different health care coverage or change your current coverage:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, changes in student status, etc.
- The employee becomes entitled to coverage under Medicare

The examples in this definition are not exhaustive and may change. Please call Customer Service for more information about qualifying events.

**Reimbursement**
The amount BCBSM pays for a covered procedure. BCBSM’s reimbursement is based on the lesser of the amount billed or the BCBSM maximum payment level for that procedure on the date the service is provided, minus any cost-sharing you are required to pay.

**Rider**
A document that amends this certificate by adding, limiting, deleting or clarifying benefits.

**Right of Recovery**
The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

**Services**
Care, procedures and supplies given by a dental care provider to diagnose or treat dental conditions.

**Spouse**
An individual who is legally married to the subscriber.
**Subrogation**
When BCBSM assumes the right to make a claim against or to receive money or another thing of value from another person, insurance company or organization. This right can be your right or the right of your dependents or representatives.

**Subscriber**
The person who signed and submitted the application for coverage and meets the group’s eligibility requirements.

**Supervision**
When a dentist oversees the care of a patient, is available when necessary, but is not at chair side while service and treatment are rendered.

**Termination**
An action that ends a member’s coverage after the member’s contract takes effect. This results in the member’s contract being in effect up until the date it is terminated.

**We, Us, Our**
Used when referring to Blue Cross Blue Shield of Michigan.

**You and Your**
Used when referring to any person covered by the subscriber's contract.
Section 8: Additional Information You Need to Know

We want you to be satisfied with our how we administer your coverage. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Dental Network of America (DNoA). The telephone number is on the back of your Blues ID card and the top right hand corner of your Explanation of Benefits statements.

Grievance and Appeals Process

DNoA has a formal grievance and appeals process. This process allows you to dispute issues that you could not resolve using DNoA’s Customer Service. You can also dispute an adverse benefit decision or termination or cancellation of your coverage.

An adverse benefit decision is a:

- Denial of a request for benefits
- Reduction in benefits
- Failure to pay for an entire service or part of a service, or
- Decision to rescind coverage

You may file a grievance or appeal about any adverse benefit decision. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges.
- You may submit materials or testimony at any step of the process to help DNoA in its review.
- You may authorize another person, including your dentist, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the Customer Service number on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.
- Although DNoA has 60 days to give you our final determination for post-service appeals, you have the right to allow it additional time if you wish.
- You do not have to pay for copies of information relating to DNoA’s decision to deny, reduce or rescind your coverage.

The grievance and appeals process begins with an internal review by DNoA. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.
Section 8: Additional Information You need to Know

Standard Internal Review Process

Step 1: You or your authorized representative sends DNoA a written statement explaining why you disagree with its decision.

Mail your written grievance to:

Dental Network of America  
Dental Executive Inquiry Unit  
701 E. 22nd St., Suite 300  
Lombard, IL 60148-5095

Step 2: DNoA will contact you to schedule a telephone conference once it receives your grievance. During your conference, you can provide DNoA with any other information you want it to consider in reviewing your grievance. The written decision DNoA gives you after the conference is the final decision.

Step 3: If you disagree with the final decision or you do not receive the decision within 60 days after DNoA received your original grievance, you may request an external review. See below for how to request a standard external review.

Standard External Review Process

Once you have gone through the standard internal review process, you or your authorized representative may ask for a standard external review.

Before you file a request for an external review, you must exhaust the internal review process above, unless:

1. DNoA waives the exhaustion requirement;

2. DNoA fails to comply with the requirements of its internal appeals process, unless those failures are legally insignificant; or

3. You simultaneously request an expedited internal review and an expedited external appeal.

You may ask for a review of any adverse benefit decision as defined above, or any rescission of your coverage. There is no fee to request an external review.

The standard external review process is as follows:

Within 120 days of the date you receive or should have received DNoA’s final decision, send a written request for an external review to the Department listed below.

Mail your request, including the required forms that DNoA gives you to:

Department of Insurance and Financial Services  
Office of General Counsel  
Health Care Appeals Section  
P.O. Box 30220  
Lansing, MI 48909-7720
Grievance and Appeals Process (continued)

Standard External Review Process (continued)

When you file a request for an external review, you will have to authorize the release of medical or dental records that may be required to reach a decision during the external review.

If you ask for an external review about a dental issue and the issue is found to be appropriate for external review and involves a medical judgment, the Department will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers. The independent review group will make a recommendation to the Department. The Department will make a decision on the external review and it will be binding on you, DNoA and BCBSM. The Department will make sure that this independent review group does not have a conflict of interest with you, with us, or with any other relevant party. If the issue does not involve medical judgment, the Department will conduct the external review.

Reviews of Dental Issues Involving Medical Judgment

Step 1: The Department will assign an independent review group to review your request if it concerns a dental issue that is appropriate for an external review.

You can give the Department additional information within seven days of asking for an external review. DNoA must give the independent review group all of the information it considered when it made its final decision, within seven days of getting the notice of your request from the Department.

Step 2: The review group will recommend within 14 days whether the Department should uphold or reverse DNoA’s decision. The Department must decide within seven business days whether to accept the recommendation and then notify you of its decision. The decision is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Reviews of Dental Issues Not Involving Medical Judgment

Step 1: The Department’s staff will review your request if it involves dental issues not involving medical judgment and is appropriate for an external review.

Step 2: They will recommend if the Department should uphold or reverse DNoA's decision. The Department will notify you of the decision. This is your final administrative remedy under the Patient’s Right to Independent Review Act of 2000.

Expedited Internal Review Process

- You may file a request for an expedited internal review if your dentist shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:
  - Your life or health or
  - Your ability to regain maximum function
Grievance and Appeals Process (continued)

Expedited Internal Review Process (continued)

You may request an expedited internal review if you believe:

- DNoA wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it or
- DNoA failed to respond in a timely manner to a request for benefits or payment

The process to submit an expedited internal review is as follows:

Step 1: Call 313-225-6800 to ask for an expedited internal review. Your dentist should also call this number to confirm that you qualify for an expedited internal review.

Step 2: DNoA must give you its decision within 72 hours of receiving both your grievance and the dentist’s substantiation.

Step 3: If you do not agree with DNoA’s decision, you may, within 10 days of receiving it, request an expedited external review.

Expedited External Review Process

If you have filed a request for an expedited internal review, you or your authorized representative may ask for an expedited external review from the Department of Insurance and Financial Services.

You may request an expedited external review if you believe:

- DNoA wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it or
- DNoA failed to respond in a timely manner to a request for benefits or payment

The expedited external review process is as follows:

Step 1: A request for an Expedited External Review form will be sent to you or your representative with DNoA’s final adverse determination.

Step 2: Complete this form and mail it to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Grievance and Appeals Process (continued)

Expedited External Review Process (continued)

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

Step 3: The Department will decide if your request qualifies for an expedited review. If it does, the Department will assign an independent review group to conduct the review. The group will recommend within 36 hours if the Department should uphold or reverse DNoA’s decision.

Step 4: The Department must decide whether to accept the recommendation within 24 hours. You will be notified of the Department’s decision. This decision is the final administrative remedy under the Patient’s Right to Independent Review Act of 2000.

Pre-Service Appeals

For members who must get approval before obtaining certain health services.

Your plan may require predetermination of certain dental services. If predetermination is denied, you can appeal the decision.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the Customer Service number on the back of your Blues ID card.

All appeals must be requested in writing. DNoA must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a Standard Pre-Service Review

You may make the request yourself, or your dentist or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the Customer Service number on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

Your request for a review must include:

- Your contract numbers, found on your Blues ID card
- A daytime phone number for both you and your representative
- The patient's name if different from yours and
- A statement explaining why you disagree with DNoA’s decision and any additional supporting information

Once DNoA receives your appeal, it will provide you with its final decision within 30 days.
Pre-Service Appeals (continued)

Requesting an Urgent Pre-Service Review

If your situation meets the definition of urgent under the law, your request will be reviewed as soon as possible; generally within 72 hours. Generally, an urgent situation is one that concerns an admission, availability of care, continued stay, or health care service for which you have received emergency services, but have not been discharged. A situation is also urgent if the standard External Review time frame would seriously jeopardize your life, health, or ability to regain maximum function. If you believe your situation is urgent, you may request an urgent review or a simultaneous expedited external review.

See above for the steps to follow to request an expedited external review. For more information on how to ask for an urgent review or simultaneous expedited external review, call the customer service number on the back of your Blues ID card.

Need More Information?

At your request and without charge, DNoA will send you details from your dental care plan if the decision was based on your benefits. If the decision was based on medical guidelines, DNoA will provide you with the appropriate protocols and treatment criteria. If DNoA involved a medical expert in making this decision, DNoA will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the Customer Service number on the back of your Blues ID card.

Other resources to help you

You can contact the Director of the Michigan Department of Insurance and Financial Services for assistance.

To contact the Director:

Call toll-free at 1-877-999-6442 or

Mail to: Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720
Section 8: Additional Information You need to Know

We Speak Your Language

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thể thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 제공 받을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, যা আপনি সাহায্য করছেন এমন কার্য, সাহায্য প্রদান হয়, তাহলে আপনার ভাষায় বিভাগীয় সাহায্য ও ভাষা পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন পোষাকের সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায্য সম্পর্কে কল করলে বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebującej pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.
Section 8: Additional Information You need to Know

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiamale il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important Disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

Section 9: How to Reach Us

This section lists phone numbers and addresses to help you get information quickly.

Call us

If you have questions about claims or coverage, you can call customer service at 888-826-8152 Monday through Friday from 8 a.m. to 6 p.m. Eastern Time.

Please have your ID card with your group and contract numbers ready when you call us.

Write us

Dental Network of America
Dental Executive Inquiry Unit
701 E. 22nd St., Suite 300
Lombard, IL 60148-5095

Check Our Website

You can visit bcbsm.com 24/7 to get general information about us or find a PPO or participating dentists near you. From there, you can:

- Sign in to access information about your Blue Dental coverage
- Review copies of your Explanations of Benefits
- Use our Dental Cost Advisor

You can also visit our online Dental Wellness Center to:

- Access a wealth of information on dental health topics
- Ask questions of licensed dentists
- Take oral health risk assessments and more

Visit www.mibluedentist.com to locate a dental provider in your area.
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