



**Blue Cross
Blue Shield
Blue Care Network**
of Michigan

Confidence comes with every card.®

BLUE DENTALSM PEDIATRIC INDIVIDUAL MARKET BENEFITS CERTIFICATE

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 Section 9 of this certificate for our mailing address and Dental Customer Service telephone number.



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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, the subscriber agrees 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.

BLUE DENTAL PEDIATRIC
INDIVIDUAL MARKET BENEFITS
CERTIFICATE

This Blue Cross Blue Shield of Michigan (BCBSM) dental coverage is designed to help you and your eligible dependents maintain healthy smiles. 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 this coverage, please call us at 1-888-826-8152 or log into your Member Account at <http://www.bcbsm.com/>.

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

About Your Certificate

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

- **Table of Contents** – for quick reference
- **Information About Your Contract**
- **What You Must Pay**
- **Coverage for Dental Services**
- **Exclusions and Limitations**
- **How Dental Benefits Are Paid**
- **General Conditions of Your Contract**
- **Definitions** – explanations of the terms used in your certificate
- **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 Blue Dental coverage.

If you have any questions, please call Dental Customer Service at **1-888-826-8152**. Calls are answered by the interactive voice response system 24 hours a day, 7 days a week. Live Customer Service Representatives are available Monday through Friday from 8 a.m. to 7 p.m. Eastern Time.

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

The **subscriber** is the individual who signed the application for coverage.

The term **member** refers to the pediatric member who receives dental services. Eligible pediatric members are those listed on the 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**
 - Who Is Eligible to Receive Benefits
- **WHEN YOU CAN ENROLL**
- **WHEN YOUR BENEFITS BEGIN**
- **CHANGING YOUR COVERAGE**
- **TERMINATION**
 - How to Terminate Your Coverage
 - How We Terminate Your Coverage
 - Rescission
- **BILLING**
 - Information About Your Bill
 - How Rates are Classified

ELIGIBILITY

Who Is Eligible to Receive Benefits

Only pediatric members can be covered under this certificate. Pediatric members include:

- An independent individual who is:
 - 18 years of age or younger on the plan's effective date
 - Enrolled as a subscriber in a qualified health plan or medical plan
 - A current resident of Michigan on the effective date of coverage and a U.S. citizen or lawfully present in the United States and must intend to live in the state, except in the case of individuals living outside of Michigan temporarily (as in the case with college students or snowbirds)



- The subscriber's spouse and dependent children may also be covered under this certificate if they are 18 years of age or younger on the plan's effective date.

Or

- A dependent child who is:
 - 18 years of age or younger on the plan's effective date
 - Enrolled under this certificate by a qualified health plan or medical plan subscriber. The subscriber must be someone legally authorized to sign a contract on the dependent child's behalf or related to the child by:
 - Birth
 - Marriage
 - Legal adoption
 - Legal guardianship
 - Child support order or other court order
 - Foster child placement by an agency or court order
 - A current resident of Michigan on the effective date of coverage and a U.S. citizen or lawfully present in the United States and must intend to live in the state, except in the case of individuals living outside of Michigan temporarily (as in the case with college students or snowbirds)



The spouse or children of a dependent child are not covered under this certificate.

To get coverage:

- Independent individuals who are 18 years of age or younger on the plan's effective date can apply for their own pediatric dental coverage. They must complete and submit their applications for coverage. **These individuals are subscribers.**
- For a dependent child, a parent, legal guardian or someone who is legally authorized to sign a contract on behalf of the dependent child must complete and submit the child's application for coverage. **In this situation, the parent or person who signs a contract for the dependent child is the subscriber.**

We will review the application to determine if the subscriber or dependent child is eligible for coverage. Our decision will be based on the terms of this certificate and our underwriting policies that are in effect at the time of application.



If the subscriber commits fraud or intentionally lies about a material fact when filling out the application, this coverage may be rescinded. The subsection that explains "*Rescission*" is on page 7.

If you or anyone applying for coverage on your behalf lies about your state or county of residence, we have the right to get back from you the difference in premium from what you are paying and what you should have paid.

We will pay for services listed in this certificate or a Blue Dental rider only for members who are 18 years of age or younger on the date their coverage begins. These individuals will receive pediatric dental benefits until the end of the calendar year in which they turn age 19.

If the subscriber's qualified health plan or medical plan is terminated or if a dependent child is removed from the qualified health plan or medical plan, dental benefits will also end.

When a member no longer qualifies for benefits under this certificate, that individual or their 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.

WHEN YOU CAN ENROLL

- If this coverage was purchased **on** the Marketplace, you can enroll:
 - During the annual open enrollment period
 - Up to 60 days after a qualifying event
 - At other times of the year as allowed by federal law
- If this coverage was purchased **off** the Marketplace, you can enroll:
 - During the annual open enrollment period
 - At any time during the calendar year; this coverage does not require a qualifying event

WHEN YOUR BENEFITS BEGIN

Covered benefits and services are available on the effective date of this contract.

CHANGING YOUR COVERAGE

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

The subscriber has the option to change who can receive benefits under this current coverage if there is a qualifying event, including, but not limited to:

- Birth
- Adoption
- Gaining a dependent due to:
 - A child support order or other court order
 - Foster child placement by agency or court order
- Marriage
- Divorce
- Death of a member
- Start or end of military service

If the subscriber purchased this coverage **on** the Health Insurance Marketplace (Marketplace), the subscriber must notify the Marketplace within 60 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.

Changing Your Coverage (continued)

If the subscriber purchased this coverage **off** the Marketplace, we must receive notice within 60 days of when a dependent or spouse is added to or removed from coverage. 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 member covered under this certificate dies, please notify us, and the rate will be adjusted as of the date of death. If the subscriber dies, the contract must be rewritten to reflect a new subscriber and the rate will be adjusted. In either event, the subscriber may not change this coverage until the next open enrollment period, except as established by federal law.

Once the subscriber receives a new ID card, do not use the old one. However, keep the old card until all claims incurred under the former dental policy or contract have been processed.

TERMINATION

How to Terminate Your Coverage

We will accept termination of this coverage only from the subscriber, the parent, guardian, or legal representative of the person(s) listed on this policy. This coverage will be terminated and all benefits under this certificate will end. A refund or credit will be given for the pro-rated share of any premiums that were prepaid.

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

If the subscriber purchased this coverage **on** the Marketplace, it may be terminated only if the subscriber contacts the Marketplace with proper notice. Once the subscriber provides 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 the subscriber purchased this coverage **off** the Marketplace, call or send us a written request to terminate this coverage at the phone number or address listed in Section 9. The subscriber may also call the phone number on their BCBSM identification card.



If the subscriber decides to terminate this coverage within 10 days after the date that it is effective, they will be given a full refund of the premium that was paid. If this coverage is terminated after it has been effective for 10 days, the subscriber will be given a pro-rated refund of any unused portion of the premium.

How We Terminate Your Coverage

A subscriber's coverage automatically ends when they are no longer eligible for coverage under this certificate.

A dependent child's coverage automatically ends when they are 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 who may also be on this contract will remain active.

We may terminate this coverage if:

- The subscriber does not pay the bill on time.
- The subscriber or a dependent child under this certificate is serving a criminal sentence for defrauding BCBSM.
- We no longer offer this coverage.
- The subscriber or a dependent child cannot provide proof they are a Michigan resident.
- The subscriber or a dependent child **misuses** this coverage. **Misuse** includes illegal or improper use of this coverage such as:
 - Allowing an ineligible person to use this coverage
 - Requesting payment for services that were not received
- The subscriber terminated their qualified health plan or medical plan.
- A dependent child ceases to have a qualified health plan or medical plan.
- The subscriber fails to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to their rights under the appeals process.
- The subscriber under this certificate is satisfying a civil judgment in a case involving BCBSM.
- The subscriber under this certificate is repaying BCBSM funds received illegally.

This coverage will end on the last day covered by the last premium payment. If the subscriber or dependent child is no longer eligible for coverage because of age, coverage will end on the last day of the calendar year in which that individual turns age 19.

If we terminate this coverage, we will provide 30 days' notice, along with the reason for the termination.

Rescission

We will rescind coverage if the subscriber or dependent child has:

- Performed an act, practice or omission that constitutes fraud, or
- Intentionally lied about a material fact to BCBSM or another party, which results in the subscriber or a dependent child obtaining or retaining this coverage with BCBSM, or the payment of claims under this or another BCBSM certificate.



We may rescind this coverage back to the effective date of this contract. If we do, we will provide a 30-day notice. Once we notify the subscriber that we are rescinding this coverage, we may hold or reject claims during this 30-day period. The subscriber must repay BCBSM for its payment for any services received.

BILLING

Information About Your Bill

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

If this coverage was purchased **on** the Health Insurance Marketplace (Marketplace) and the Marketplace determines the subscriber is eligible for a premium tax credit (subsidy):

- The subscriber is responsible only for the subscriber's portion of the premium, not any applicable amount covered by the subsidy.
- The subscriber must pay the premium by the due date printed on the bill for this coverage. When we receive payment, we will continue this coverage through the period that has been paid.
- The subscriber may get subsidies only if:
 - This coverage was purchased on the Marketplace

If the subscriber is receiving an advance payment of a federal premium tax credit and has paid at least one full month of premium during the current benefit year, they will be given a three-month grace period before we will terminate or cancel this coverage for not paying the premium when due. If a member receives 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 payment in full for all premiums due before the grace period ends, this coverage will be terminated or cancelled. The 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.

Information About Your Bill (continued)

If the subscriber purchased this coverage either on or off the Marketplace but is not eligible for a subsidy, then the following apply:

- The subscriber is responsible for the entire premium amount.
- The subscriber must pay the premium by the due date printed on the bill. When we receive payment, we will continue this coverage through the period that has been paid.
- The three-month grace period does not apply if the subscriber does not receive a premium tax credit. If we do not receive premium payment by the due date, we will allow a grace period of 31 days, during which we will send a final bill. If we do not receive premium payment during the grace period, this 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 the subscriber, or their spouse, or when appropriate, from a parent, blood relative, legal guardian or other person or entity that is allowed by law to pay premiums on the member's behalf.

How Rates Are Classified

The rate for this coverage will be based upon certain rating factors such as age and where members live, in accordance with federal law.

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 explains 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. A rider that amends this certificate will tell you if you have a 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 a non-covered service.

Coinsurance Requirements

Coinsurance (if any) is the portion of the approved amount that you must pay for covered services. A rider will indicate your coinsurance.

We will not apply a coinsurance to:

- The difference between our approved amount and the dentist's charge.
- Non-covered services.

Pediatric Out-of-Pocket Maximum

This is the maximum out-of-pocket cost you will pay in a calendar year for deductibles and coinsurances that are required for covered dental services provided to pediatric members by Tier 1 PPO (in-network) dentists. Only cost sharing you pay for covered services provided by Tier 1 PPO (in-network) 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 these services for the remainder of the calendar year.

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

- Are for services provided by non-PPO (out-of-network) dentists
- Exceed our approved amount
- Are for non-covered services

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 for any exclusions and limitations.

Class I – Diagnostic and Preventive Services

- **Diagnostic and preventive services** – evaluate existing conditions, prevent oral disease, and stop the progress of disease already present. These services include:
 - Oral examinations/evaluations
 - Prophylaxes
 - Fluoride treatments
- **Bitewing radiographs (X-rays) and individual periapical films** – as needed for routine care or to detect specific conditions.
- **Oral brush biopsy sample collection** – identifies cancerous and precancerous cells.

Class II – Basic Services

- **Other diagnostic and preventive services:**
 - Diagnostic tests and laboratory examinations
 - Dental sealants
 - Space maintainers
- **Full-mouth and panoramic radiographs (X-rays).**
- **Emergency palliative treatment** – provides temporary pain relief.
- **Minor restorative services** – 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

Class II – Basic Services (continued)

- **Simple extractions.**
- **Non-surgical endodontic services** – 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
- **Non-surgical periodontic services** – 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** – are provided 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. To be considered necessary, one of the following criteria must be met:
 - Significant cellulitis or swelling and the associated inability to open the mouth fully does not allow the use of local anesthesia at the site of the injection
 - Treatment is for bilateral alveolectomy, bilateral alveoloplasty, bilateral surgical exposures or bilateral tori
 - Six or more teeth in various quadrants are removed on the same date of service
 - Two or more impacted teeth are removed on the same date of service
 - Four third molars are removed on the same date of service
 - Patient is medically impaired or compromised
 - Patient is allergic to local anesthesia
 - Patient is younger than age seven

Dentists must provide the reason general anesthesia or IV sedation was needed and a description of the services that were performed.

 - Office visits after regularly scheduled hours
 - Consultations by dentists not providing treatment
- **Basic prosthodontic services** – replace missing natural teeth. These services include:
 - Adjustments, repairs, relines, rebases and tissue conditioning for prosthodontic appliances
 - Recementation of fixed bridges

Class III – Major Services

- **Major restorative services** – 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
- **Oral surgery services** – include the procedures listed below. They do not include simple extractions, which are covered at Class II:
 - 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
 - Alveoloplasty needed to prepare for a denture
 - Removal of exostoses (excess bony growths of the upper and lower jaw)
 - Excision of hyperplastic tissue per arch
 - Frenulectomies
- **Surgical endodontic services** – treat teeth with diseased or damaged nerves. These services include:
 - Apical surgeries on permanent teeth
 - Hemisections
- **Surgical periodontic services** – treat diseases of the gums and the structures that support the teeth. These services include:
 - Periodontal scaling and root planing
 - Gingivectomies and gingivoplasties
 - Gingival flap procedures
 - Soft tissue grafts
- **Prosthodontic services** – 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
 - Porcelain, ceramic and cast metal retainers for resin-bonded bridges
 - Repairs of bridges
 - Stayplates to replace recently extracted permanent anterior (front) teeth

Section 4: Exclusions and Limitations

The services listed in this section are in addition to all other services **we do not cover**, which are stated elsewhere 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 member in the hospital.
- Services to correct birth defects or developmental defects, such as amelogenesis imperfecta, 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 and supplies 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 they work under the supervision of a dentist and the hygienist is licensed to perform the services.
- Office visits for observation.
- House and hospital calls.
- Drugs that are not parenterally administered by a dentist in connection with covered services.

Exclusions (continued)

- Antibiotic injections.
- Local anesthetic or analgesic billed as a separate service.
- Desensitizing medications.
- Supplies and barrier techniques used for infection control.
- Rubber dams.
- 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.
- Replacing lost, missing, or stolen restorations, appliances or prosthetics of any type.
- Replacing or repairing space maintainers or orthodontic appliances.
- Diagnostic photographs, skull and facial bone survey films or imaging of any type.
- 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.
- 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

Exclusions (continued)

- 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):
 - Bases
 - Etchings
 - 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.
- Occlusal biteguards.
- Occlusal adjustments.
- Inlays, except under very limited circumstances with individual consideration by report.
- 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.
- Localized delivery of anti-microbial agents.
- 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.
- Osseous surgery.
- Bone replacement grafts.
- 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.

Exclusions (continued)

- Retreatments of root canals by the same dentist within 12 months of the initial 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 surgical barriers and guided tissue regeneration.
- 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.
- 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 (TMJ) dysfunction.
- Orthodontia and related services.
- 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:

- Periodic oral examinations/evaluations – twice every calendar year.
- Comprehensive oral examinations/evaluations – once per dentist/dental office every 60 months. If this is a child's first oral exam, it should take place when the first tooth erupts, but no later than that child's first birthday.
- Any combination of cleanings (prophylaxes, scaling in the presence of inflammation and periodontal maintenance) – three times every calendar year.
- A set (up to four films) of bitewing X-rays – once every calendar year.

Limitations (continued)

- Individual periapical films (up to six) – once every calendar year.
- A full-mouth series of X-rays or panoramic X-rays (including bitewing and periapical X-rays taken on the same day) – once every 60 months.
- 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 members to the end of the month of their 19th birthday. For members under age three, topical fluoride varnishes four times every calendar year.
- Dental sealants – once per fully erupted first and second permanent molar every 36 months for members to the end of the month of their 16th birthday.
- Space maintainers – once per quadrant every two years for members to the end of the month of their 15th birthday.
- Oral brush biopsy sample collection – twice every calendar year.
- Replacement fillings for permanent teeth – once per tooth and surface every 48 months.
- Replacement fillings for primary teeth – once per tooth and surface every 24 months.
- Recementing the following items – three times per tooth every calendar year:
 - Posts
 - Crowns
 - Veneers
 - Inlays
 - Onlays
 - Fixed partial dentures (bridges)
- Root canal treatment for a tooth involving one or more canals – once per tooth per lifetime.
 - Retreatment of a root canal – once per tooth per lifetime.
- Hemisections, not including root canal therapy for permanent teeth – once per tooth per lifetime.
- Periodontal scaling and root planing – once per quadrant every 24 months.

Limitations (continued)

- Periodontic surgical services – once per quadrant every 36 months.
- Onlays, crowns and veneers – once per tooth every 60 months when the tooth cannot be restored with another filling material.
- Substructures – once per permanent tooth every 60 months for members age 12 and older.
- Provisional crowns – once every 24 months for members age 18 and younger.
- Prefabricated stainless steel or resin crowns – once per tooth every 12 months for members age 18 and younger.
- Relines or rebases of removable partial or complete dentures – once per arch every 36 months.
- Tissue conditioning – once per arch every 36 months.
- 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 costs will be lowest when you choose a Tier 1 PPO (in-network) dentist.

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

- **Tier 1 PPO (In-Network) Dentist** – A dentist who has signed a PPO contract and agrees to accept our approved amount as full payment for covered services.
- **Tier 2 Participating Non-PPO (Out-of-Network) Dentist** – A non-PPO (out-of-network) dentist who participates with us on a per-claim basis and agrees to accept our approved amount as full payment for covered services.
- **Nonparticipating Dentist** – A non-PPO (out-of-network) dentist who does not participate with us on a per-claim basis and has not agreed to accept our approved amount as full payment for covered services. A nonparticipating dentist may bill you for any difference between what we paid you for covered services and the amount they charged for the services.

If your dentist is a Tier 2 participating non-PPO (out-of-network) dentist, you should always ask if they agree to participate with us for every service provided.

If you choose to get services from a nonparticipating dentist, you will have to pay any difference between our reimbursement and what the dentist charges.

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

Predetermination of Benefits

Your dentist may, but is not required to, submit their 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 treatment will produce acceptable results at a lower cost, the most we will pay is our approved amount for the alternative treatment. If you and your dentist choose the treatment plan that was originally 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 predetermined services is based on the benefits that are available to you on the date the services are actually provided, and on the requirements, terms and conditions of this certificate.

An approved predetermination is valid for 12 months. If the services have not been completed within that time, you can ask for a new predetermination.

Filing Claims

Within 24 months of the date services were completed, you or your dentist must file a claim for benefits on the required form before we 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 in the state of Michigan. Below is a description of how we pay for covered services.

- **Tier 1 PPO (In-Network) Dentists**

Tier 1 PPO (in-network) dentists agree to accept our approved amount as payment in full for covered services. We pay Tier 1 PPO (in-network) dentists directly. You are responsible only for cost-sharing amounts required by your plan, as well as any charges for non-covered services.

Our approved amounts for Tier 1 PPO (in-network) dentists are generally lower than our approved amounts for non-PPO (out-of-network) dentists, so the cost-sharing amounts you are responsible for may also be lower.

- **Tier 2 Participating Non-PPO (Out-of-Network) Dentists**

Non-PPO dentists can participate on a per-claim basis by indicating on the claim form that we should pay them directly for covered services. When they do this, they enter into a contract with us and agree to accept our approved amounts as full payment for covered services. When you receive services from a Tier 2 participating non-PPO (out-of-network) dentist, you are responsible only for cost-sharing amounts required by your plan, 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 they provide. If your dentist indicates that they will not participate with us for a particular service and you still choose to have them provide that service, you are responsible for any costs that exceed our reimbursement.

- **Nonparticipating Dentists**

When non-PPO dentists do not participate with BCBSM, we will pay you directly for covered services. Our payment will be the lesser of the amount billed or our approved amount, minus any cost sharing required by your plan, as well as any charges for non-covered services. You are responsible for the entire amount charged by your dentist, which may be higher than our reimbursement.

Understanding Our Payment—Your Explanation of Benefits

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

- The names of the dentist and the member
- 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 approved, 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 Dental Customer Service 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 Address

You must notify us of any changes in your address. An enrollment/change of status form should be completed when you change your address.

Changes in Your Family

You must notify us of any changes in your family. Changes include marriage, divorce, birth, death, adoption, or the start or end of military service.

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

If you purchased this coverage **off** the Marketplace, we must receive notice from you within 60 days of when a dependent or spouse is added to or removed from coverage. Contract changes take effect as of the date of the event.

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 coordinate benefits payable under this certificate per Michigan's Coordination of Benefits Act.



It is the member's responsibility to provide complete and accurate information when requested by us to coordinate benefits. Failure to provide the requested information, including information about other coverage, may result in denial of claims. If claims are not covered due to your failure to update this information, you may be responsible for the full amount of your provider's charges.

Coordination of Benefits (continued)**Provisions per Michigan's Coordination of Benefits Act (MCL 550.253)****Guidelines to Determine Primary Coverage If You Are Covered by Two or More Plans**

- (1) If an individual is covered by 2 or more plans, the rules for determining the order of benefit payments are as follows:
 - (a) The insurer that issues the primary plan shall pay or provide benefits as if a secondary plan does not exist.
 - (b) If the individual is covered by more than 1 secondary plan, the order of benefit determination rules under this act determine the order under which secondary plan benefits are determined in relation to each other. An insurer that issues a secondary plan shall take into consideration the benefits of the primary plan and the benefits of any other plan that are, under this act, determined to be payable before those of the secondary plan.
 - (c) Subject to subdivision (d), a plan that does not contain order of benefit determination provisions that are consistent with this act is always the primary plan unless the provisions of both plans, regardless of this subdivision, state that the complying plan is primary.
 - (d) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the insurer that issues the secondary plan shall pay or provide benefits as if it were the primary plan if a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the insurer that issued the primary plan.

Order of Benefit Payments

- (2) The order in which benefits are payable by insurers that issue plans are determined by using the first of the following rules that applies:
 - (a) The nondependent/dependent rule. If the individual is not a dependent but is an employee, member, subscriber, policyholder, or retiree under 1 plan and is a dependent under another plan, the order of payment of benefits under the plans is determined as follows:
 - (i) Except as otherwise provided in subparagraph (ii), the plan that covers the individual other than as a dependent is the primary plan and the plan that covers the individual as a dependent is the secondary plan.
 - (ii) If the individual is a Medicare beneficiary and, as a result of the provisions of title XVIII of the social security act, 42 USC 1395 to 1395III, Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent, then the order of benefits is reversed and the plan covering the individual as other than a dependent is the secondary plan and the plan covering the individual as a dependent is the primary plan.
 - (b) The dependent covered under more than 1 plan rule. If the individual is a dependent child, unless there is a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the dependent child is determined as follows:

Coordination of Benefits (continued)

- (i) If the child's parents are married or are living together, whether or not they have ever been married, as follows:
 - (A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.
 - (B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
- (ii) If the child's parents are divorced, separated, or not living together, whether or not they have ever been married, as follows:
 - (A) If a court order or judgment states that 1 of the parents is responsible for the dependent child's health care expenses or health care coverage and the insurer that issued the plan of the parent with responsibility has actual knowledge of the terms of the order or judgment, that plan is the primary plan. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This sub-subparagraph does not apply with respect to a plan year during which benefits are paid or provided before the insurer has actual knowledge of the terms of the court order or judgment.
 - (B) If a court order or judgment states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits is determined in the manner prescribed in subparagraph (i).
 - (C) If a court order or judgment states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits is determined in the manner prescribed in subparagraph (i).
 - (D) If there is no court order or judgment allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows, in the following order of priority:
 - (i) The plan covering the custodial parent.
 - (ii) The plan covering the custodial parent's spouse.
 - (iii) The plan covering the noncustodial parent.
 - (iv) The plan covering the noncustodial parent's spouse.
- (iii) If the child is covered under more than 1 plan of individuals who are not the parents of the child, the order of benefits is determined in the manner prescribed in subparagraph (i) or (ii), as applicable, as if those individuals were parents of the child.
- (iv) If the child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in subdivision (e). If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule prescribed in subparagraph (i) to the dependent child's parents, as applicable, and his or her spouse.

Coordination of Benefits (continued)

- (c) The active, retired, or laid-off employee rule. If the individual is an active employee, laid-off employee, or retired employee, or is a dependent of an active employee, laid-off employee, or retired employee, the order of payment of benefits under the plans covering the individual is determined as follows:
 - (i) The plan that covers the individual as an active employee or as a dependent of an active employee is the primary plan. The plan that covers the individual as a laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the secondary plan.
 - (ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.
 - (iii) This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree or the individual as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan.
- (d) The continuation coverage rule. If the individual has coverage under a right of continuation pursuant to federal or state law, the order of payment of benefits under the plans covering the individual is determined as follows:
 - (i) The plan that covers the individual as an employee, member, subscriber, enrollee, or retiree or as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan. The plan that covers the individual under the continuation coverage is the secondary plan.
 - (ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.
 - (iii) This rule does not apply if the order of benefits can be determined by the rule in subdivision (a).
- (e) The longer or shorter length of coverage rule. If the rules in subdivisions (a) to (d) do not determine the order of benefits, the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. To determine the length of time an individual has been covered under a plan, 2 successive plans are treated as 1 if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended. Any of the following changes do not constitute the start of a new plan:
 - (i) A change in the amount or scope of a plan's benefits.
 - (ii) A change in the entity that pays, provides, or administers the plan's benefits.
 - (iii) A change from 1 type of plan to another, such as from a single-employer plan to a multiple-employer plan.

Coordination of Benefits (continued)**Length of Time Covered under a Plan**

- (3) A person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

Plan Inability to Agree on Order of Benefits

- (4) If the insurers that issued plans cannot agree on the order of benefits within 30 calendar days after the insurers have received all of the information needed to pay the claim, the insurers shall immediately pay the claim in equal shares and determine their relative liabilities following payment. An insurer is not required to pay more than it would have paid had the plan it issued been the primary plan.

Amount to be Paid by the Secondary Plan

- (5) Except as provided in subsection (6), in determining the amount to be paid on a claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, the insurer shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense under its plan that is unpaid under the primary plan. The insurer that issued a secondary plan may reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the total allowable expense for the claim.

Amount to be Paid by the Secondary Plan

- (6) In determining the amount to be paid on a dental plan claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, it may do so in accordance with subsection (5) or, for not more than 2 years after the effective date of the amendatory act that added this subsection, it may do so under a nonduplication of benefits method. Under a nonduplication of benefits method, the primary plan payment is subtracted from the secondary plan's allowable benefit amount. If there is a positive balance, the insurer that issued the secondary plan shall make a payment equal to the difference. If there is a negative or zero balance, the insurer that issued the secondary plan shall make no payment. If an insurer that issues a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the internal revenue code of 1986, 26 USC 223, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the internal revenue code of 1986, 26 USC 223.

Coordination of Benefits (continued)**Payment of Claims or Coordination of Benefits not Provided or Authorized by Health Maintenance Organization**

- (7) A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract.

Deductibles, Copayments and Coinsurances Paid Under Other Certificates

We do not pay any cost sharing that you must pay under any other certificate. An 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 certificate, including your riders, if any, is the entire contract of your coverage. No change to this certificate is valid until approved by a BCBSM executive officer. No agent has authority to change this certificate 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 member'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 member harm; or are not appropriate for the member'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 those 30 days have 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

If you are not receiving a tax subsidy, 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. If you are receiving a tax subsidy, the grace period is three months.

Improper Use of Contract

If you let an 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 notify you, we mail it to you or your remitting agent. This fulfills our obligation to notify you.

Payment of Covered Services

The services covered under this certificate may be combined and paid according to BCBSM's payment policies.

Personal Costs

We will not pay for:

- Transportation and travel, even if recommended by a dentist, except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Refund of Premiums

If we determine that we must refund a premium, we will refund up to a maximum of two years of payments.

Release of Information

You agree to let providers release information to us. This can include dental 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 that 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 interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances may be appealed under applicable law.

Services Before Coverage Begins and After Coverage Ends

We will not pay for any services, treatment, care or supplies provided:

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

After coverage ends, we will pay for crowns, bridges, onlays, veneers or dentures, as described in this certificate, 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.

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.

Special Programs

Blue Dental has special programs where you may receive enhanced benefits for select dental services based on your eligibility and participation. An example of an enhanced benefit may include an additional teeth cleaning if a member has a qualifying medical condition. These programs may be provided by an approved vendor or directly through us. If eligible, you will receive information on these programs or you may contact Dental Customer Service for additional information.

We may terminate any special program based on:

- Termination or cancellation of your Blue Dental coverage
- Your nonparticipation in the program
- Other factors

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
- 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

Subrogation: When Others Are Responsible for Illness or Injury (continued)**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; or
 - 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.

Subscriber Liability

At the discretion of your provider, certain technical enhancements may be employed to complement a medical or dental procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Termination of Coverage

You must notify us if you want to terminate your coverage under this certificate. Once you provide us with this notice, your coverage will end on one of the following dates:



If you purchased this coverage **on** the Marketplace, you may terminate it only if you provide the Marketplace with proper notice.

- If you notify us at least 14 days before the date you want your coverage to end, your coverage will end on your requested date, or
- If you notify us in less than 14 days before the date you want your coverage to end, we will end it on your requested date only if it is feasible for us to do so, or
- In all other cases, we will end your coverage 14 days after you request that your coverage be terminated.

If we decide to terminate your coverage under this certificate, we may 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.

Time Limit for Filing Claims

We will not pay for claims for services that are not filed within 24 months from the date of service.

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 legal 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 for 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. The terms are listed in alphabetical order.

Abutment

Connections to natural teeth or an implant that offer retention, support and stabilization of false replacement teeth.

Accidental Injury

An external force to the lower half of the face or jaw that damages or breaks sound natural teeth, periodontal structures (gums) 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. The approved amount for covered services provided by Tier 1 PPO (in-network) dentists may be different from the approved amount for covered services provided by non-PPO (out-of-network) dentists.

BCBSM

Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

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.

Coinsurance

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

Contract

This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Copayment

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

A service that is identified as payable in this certificate. Such services must be dentally necessary, as defined in this certificate, and ordered or performed by a provider who is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, 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 the claims are processed or reprocessed. Payments made toward your deductible are not altered by an audit or recovery.

Dentally Appropriate

Services that are consistent with how providers generally treat their patients. The services can be those used to diagnose or for treatment. They are based on standard practices of care and are supported by evidence of their effectiveness.

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 member'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 member'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

- **Tier 1 PPO (In-Network) Dentist**

A dentist who has signed a contract to participate in the Preferred Provider Organization (PPO) network used by BCBSM. Tier 1 PPO (in-network) dentists agree to accept our approved amount as full payment for covered services.

- **Tier 2 Participating Non-PPO (Out-of-Network) Dentist**

A non-PPO (out-of-network) dentist who participates with BCBSM on a per-claim basis through our Blue Par Select arrangement. Tier 2 participating non-PPO (out-of-network) dentists agree to accept our approved amount as full payment for covered services.

- **Nonparticipating Dentist**

A non-PPO (out-of-network) dentist who does not participate with us on a per-claim basis and has not agreed to accept our approved amount as full payment for covered services. A nonparticipating dentist may bill you for the difference between what we paid you for covered services and the amount they charged for the services.

Department of Insurance and Financial Services

The department that regulates insurers in the state of Michigan.

Effective Date

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

Exclusions

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

Experimental or Investigational Treatment

Treatment that has not been scientifically proven to be as safe and effective for treatment of the member's conditions as conventional treatment. BCBSM is responsible for deciding if the use of any service is experimental or investigational.

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 other thing of value obtained by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid because of the plaintiff's injuries.

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.

Nonparticipating Dentist

See the definition of “Dentist”.

Non-Pediatric Member

Members who are age 19 or older when their coverage begins are considered non-pediatric members.

Ordered

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

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.

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:

- Start or end of military service. Members must perform military duty for more than 30 days.
- Death of the subscriber
- Divorce
- Loss of dependent status due to age, marriage, changes in student status, etc.
- The member 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.

Remitting Agent

Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct from wages or other sums owed to the subscriber
- Pay the subscriber's BCBSM bill

Rescission

The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

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

Subrogation occurs when BCBSM assumes the right to make a claim against or to receive money or other 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 eligibility requirements.

Supervision

When a dentist oversees the care of a member, 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.

Tier 1 PPO (In-Network) Dentist

See the definition of "Dentist".

Tier 2 Participating Non-PPO (Out-of-Network) Dentist

See the definition of "Dentist".

We, Us, Our

Used when referring to Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

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 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 Customer Service. The telephone number is on the back of your ID card and the top right-hand corner of your Explanation of Benefits (EOB) statements.

Grievance and Appeals Process

We have a formal grievance and appeals process that allows you to dispute an adverse benefit decision or rescission of your coverage.

An adverse benefit decision includes a:

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

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, such as a cancellation that treats a policy as void from the time of enrollment.

You may file a grievance or appeal about any adverse benefit decision or rescission within 180 days after you receive the claim denial. 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 us in our review.
- You may authorize another person, including your physician or dentist, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the Dental Customer Service number on the back of your ID card and ask for a *Designation of Authorized Representative and Release of Information* form. Complete it and send it with your appeal.
- Although we have 60 days to give you our final determination for post-service appeals, you have the right to allow us additional time if you wish.
- You do not have to pay for copies of information relating to our decision to deny or reduce benefits or rescind your coverage.

Grievance and Appeals Process (continued)

The grievance and appeals process begins with an internal review by Blue Cross Blue Shield of Michigan. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services (DIFS).



You do not have to exhaust our internal grievance process before requesting an external review in certain circumstances:

- We waive the requirement
- We fail to comply with our internal grievance process
 - Our failure to comply must be for more than minor violations of the internal grievance process.
 - Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Standard Internal Review Process

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

Mail your written grievance to:

Blue Cross Blue Shield of Michigan
Attn: Complaints & Grievances
P.O. Box 49
Detroit, MI 48231

Step 2: We will contact you to schedule a telephone conference once we receive your grievance. During your conference, you can provide any other information you want-us to consider in reviewing your grievance. The written decision we give you after the conference is our final decision.

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

Grievance and Appeals Process (continued)**Standard External Review Process**

Once you have gone through our standard internal review process, you or your authorized representative may request an external review.

The standard external review process is as follows:

Within 127 days of the date you receive or should have received our final decision, send a written request for an external review to the Department listed below. You may mail your request and the required forms provided by us to:

Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also have your request delivered by courier or delivery to:

Department of Insurance and Financial Services
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

You may also contact the Department with your request by phone, fax, email or online:

Phone: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Online: <https://difs.state.mi.us/Complaints/ExternalReview.aspx>

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

If you ask for an external review about an issue requiring the expertise of a dental practitioner and the issue is found to be appropriate for external review, the Department will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers. The recommendation of the independent review group will only be binding on you and BCBSM if the Department decides to accept the group's recommendation. 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.

Reviews of Dental Issues

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 requesting an external review. We will provide the independent review group all of the information used for the final decision within seven days of getting the notice of your request from the Department.

Grievance and Appeals Process (continued)

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

Reviews of Nondental Issues

Step 1: The Department's staff will review your request if it involves issues that do not require the expertise of a dental practitioner and is appropriate for an external review.

Step 2: They will recommend if the Department should uphold or reverse our 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 physician or dentist shows (verbally or in writing) that following the timeframes of the standard internal review process will seriously jeopardize:
 - Your life or health, or
 - Your ability to regain maximum function

You may request an expedited internal review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you received it, or
- We 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 1-888-826-8152 to ask for an expedited internal review. Your physician or dentist should also call this number to confirm that you qualify for an expedited internal review.

Step 2: We must provide you with our decision within 72 hours of receiving both your grievance and the physician's/dentist's substantiation.

Step 3: If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Department.

Grievance and Appeals Process (continued)**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.

You may request an expedited external review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you received it, or
- We 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 external review form will be sent to you or your representative with our final adverse determination.

Step 2: Complete this form and mail it to:

Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also have your request delivered by courier or delivery to:

Department of Insurance and Financial Services
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

You may also contact the Department with your request by phone, fax, email or online:

Phone: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Online: <https://difs.state.mi.us/Complaints/ExternalReview.aspx>

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.

Step 3: The Department will decide if your request qualifies for an expedited external 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 our 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 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 Dental Customer Service number on the back of your ID card.

All appeals must be requested in writing. We 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 Dental Customer Service number on the back of your ID card 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 enrollee ID and group numbers found on your ID card;
- A daytime phone number for both you and your representative;
- The member's name if different from yours; and
- A statement explaining why you disagree with our decision and any additional supporting information.

Once we receive your appeal, we will provide you with our final decision within 30 days.

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. An urgent situation is one in which, in the opinion of your physician or dentist, your health may be in serious jeopardy or you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. 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 Dental Customer Service number on the back of your ID card.

Need More Information?

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

To request information about your plan or the medical/dental guidelines used, or if you need help with the appeal process, call the Dental Customer Service number on the back of your 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
- Fax to 517-284-8837; or
- Go online at <https://difs.state.mi.us/Complaints/ExternalReview.aspx>; or
- Mail to: Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات سهل الوصول إليها مجانًا. اتصل برقم 711 TTY: 877-469-2583 أو تحدث إلّٰى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电 877-469-2583 (TTY: 711) 或咨询您的服务提供商。

[illegible]

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다. 877-469-2583 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 877-469-2583 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 877-469-2583 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 877-469-2583 TTY: 711 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'877-469-2583 TTY: 711 o parla con il tuo fornitore.

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。877-469-2583 TTY: 711 までお電話いただくか、ご利用の事業者にご相談ください。

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-469-2583 TTY: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 877-469-2583 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 877-469-2583 TTY: 711 o makipag-usap sa iyong provider.

Discrimination Is Against The Law

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 (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711. Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these 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

Discrimination Is Against The Law (continued)

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the [Office for Civil Rights Complaint Portal website](#) or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW
Room 509, HHH Building
Washington, D.C. 20201

Phone: 800-368-1019, TTD: 800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services [Office for Civil Rights website](#)

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website:

<https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/>

Section 9: How to Reach Us

This section lists ways you can get information quickly.

Call Us

If you have questions about your claims or coverage, you can call Dental Customer Service at **1-888-826-8152**. Calls are answered by the interactive voice response system 24 hours a day, 7 days a week. Live Customer Service Representatives are available Monday through Friday from 8 a.m. to 7 p.m. Eastern Time.

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

Write Us

If you have complaints or concerns, you can write to us:

Blue Cross Blue Shield of Michigan
Attn: Complaints & Grievances
P.O. Box 49
Detroit, MI 48231

Check Our Website

If you want more information about your Blue Dental plan, you can visit <http://www.bcbsm.com/> 24/7. Log in to your member account to:

- Access information about your Blue Dental coverage
- Find Tier 1 PPO (in-network) dentists or Tier 2 participating non-PPO (out-of-network) dentists near you
- Review your Explanation of Benefits
- Review your claims

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