

DentalChoice Plan 1 Summary of Benefits

For Groups of 5-25 Enrolled Employees



An Independent Licensee of the Blue Cross and Blue Shield Association

Provider Alternatives – Out-of-pocket costs will differ depending on which type of provider is selected

DentalChoice Providers DentalChoice providers are Arizona providers who have a contract with Blue Cross Blue Shield of Arizona. Members pay lower out-of-pocket costs when they receive covered services from DentalChoice providers. DentalChoice providers will file members' claims with Blue Cross Blue Shield of Arizona. DentalChoice providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of Blue Cross Blue Shield of Arizona (BCBSAZ).

Non-Contracted Providers Non-contracted providers have no contract with BCBSAZ. Members pay higher out-of-pocket costs when they receive covered services from non-contracted providers. Non-contracted providers are not obligated to file members' claims.

BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider.

Allowed Amount The allowed amount is the amount of reimbursement allocated to a covered service.

BCBSAZ bases the allowed amount on the lesser of a provider's billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements BCBSAZ has negotiated with a DentalChoice provider. The allowed amount includes any BCBSAZ payment plus any member cost-sharing. For DentalChoice providers, BCBSAZ reimburses the provider the allowed amount, minus any portion allocated to member cost-share. For non-contracted providers, BCBSAZ reimburses the member the allowed amount, minus any portion allocated to member cost-share.

The allowed amount is the figure that BCBSAZ uses to calculate any deductible or coinsurance and to accumulate toward any annual benefit maximum. The allowed amount does not include any balance bills from non-contracted providers.

Balance Bills The balance bill refers to the amount members may be charged for the difference between a non-contracted provider's billed charges and the allowed amount. Balance bills can be substantial.

DentalChoice providers have agreed to accept the allowed amount for covered services. They will not charge members for the balance bill. They will collect only the member's cost-share portion, such as deductible and coinsurance amounts. However, when there is another source of payment, such as a liability insurer or government payer, DentalChoice providers may be entitled to collect their balance bill from the other source or from proceeds received from the other source.

Non-contracted providers have no obligation to accept the allowed amount as payment in full. **All non-contracted providers may bill you up to their full billed charges.** Members are responsible for paying up to a non-contracted provider's billed charges for covered services, even though BCBSAZ will reimburse members' claims based on the allowed amount, less any deduction for the member's cost-share portion. Depending on what billing arrangements members make with a non-contracted provider, the provider may charge members for full billed charges at the time of service or seek to balance bill members for the difference between billed charges and the amount of BCBSAZ reimbursement. The balance bill may be substantial. Any amounts paid for balance bills do not count toward deductible or the benefit maximum.

There are no contracted DentalChoice providers outside of Arizona through BCBSAZ or any other Blue Cross or Blue Shield plan in another state. If you receive services from a dental provider who is not contracted with BCBSAZ as a DentalChoice provider, the sections above regarding non-contracted providers and balance bills apply.

DentalChoice Plan 1

SUMMARY OF BENEFITS	
Deductible Deductible must be met for all covered services unless otherwise stated.	Calendar year deductible, per person – \$50 , family deductible maximum – \$150
Coinsurance	Coinsurance is a percentage members must pay for covered services after meeting the calendar year deductible. Coinsurance is based on the BCBSAZ allowed amount. A member's coinsurance percentage will vary, depending on the service provided.
Calendar Year Maximum Benefit	\$1,500 per person, per calendar year
Preventive & Diagnostic Services	BCBSAZ pays 100% , member pays 0% of the BCBSAZ allowed amount; deductible waived. <ul style="list-style-type: none"> • Oral exams – Two (2) per calendar year • Fluoride treatments (under age 19) Two (2) per calendar year • X-Rays <ul style="list-style-type: none"> o Periapical – one set per calendar year o Bitewings – one set per calendar year o Panoramic – one x-ray per calendar year o Complete – one set per any two calendar year period • Prophylaxis (cleaning) – Two (2) per calendar year Sealants
Routine Restorative <ul style="list-style-type: none"> • Amalgam fillings • Composite resin fillings 	BCBSAZ pays 80% , member pays 20% , of the BCBSAZ allowed amount, after meeting deductible.
Endodontic Services <ul style="list-style-type: none"> • Root Canal Treatment • Pulpal therapy 	BCBSAZ pays 80% , member pays 20% , of the BCBSAZ allowed amount, after meeting deductible.
Oral Surgery <ul style="list-style-type: none"> • Extractions • Treatment of jaw fractures 	BCBSAZ pays 80% , member pays 20% , of the BCBSAZ allowed amount, after meeting deductible.
Periodontic Services <ul style="list-style-type: none"> • Treatment of gum diseases and supportive tissues of the mouth 	BCBSAZ pays 80% , member pays 20% , of the BCBSAZ allowed amount, after meeting deductible.
Major Restorative Services[†] <ul style="list-style-type: none"> • Crowns • Onlays 	BCBSAZ pays 50% , member pays 50% , of the BCBSAZ allowed amount, after meeting deductible.
Prosthetic Services <ul style="list-style-type: none"> • Bridgework • Dentures 	BCBSAZ pays 50% , member pays 50% , of the BCBSAZ allowed amount, after meeting deductible.
Orthodontic Services (optional coverage)	Not a covered benefit.

Non-contracted providers may charge members for their full billed charges. After insurance reimbursement based on the allowed amount, less any deduction for the member's cost-share portion, members are responsible to pay the balance bill. The obligation to pay the balance bill continues even after the member's benefit maximum is met.

BCBSAZ Medical Coverage Guidelines are BCBSAZ medical, dental and administrative criteria that are developed from review of published peer-reviewed medical and dental literature and other relevant information and used to help BCBSAZ determine whether a service, procedure, medical device or medication is eligible for benefits under a member's benefit plan. For services to be eligible for coverage under this benefit plan, the services must, in addition to other specified requirements, be considered dentally necessary by BCBSAZ based on the BCBSAZ Medical Coverage Guidelines that are available upon request.

Note: This is only a brief summary of this benefit plan. A complete listing of all benefits, limitations and exclusions is in the benefit plan booklet and is available prior to enrollment upon request. If the benefits on this summary differ from those stated in the benefit plan booklet, the terms of the benefit plan booklet apply.

DentalChoice Exclusions & Limitations

Detailed information about benefits, limitations and exclusions is in the benefit plan booklet and is available prior to enrollment, upon request. Expenses for services that exceed benefit limitations are not covered.

- Activity therapy
- Alternative dentistry, non-traditional or alternative dental therapies, e.g., interventions, services or procedures not commonly accepted as part of dental curriculums/practices; naturopathic and homeopathic medicine; diet therapies; nutritional and lifestyle therapies; aromatherapy
- Appliances, procedures, devices and services necessary to increase vertical dimension and restore an occlusion
- Athletic mouth guards – any procedures and services necessary to fabricate or create such mouth guards
- Behavior management of any kind
- Bleaching of any kind; both internal and external bleaching
- Body art, piercing, tattooing and related complications.
- Complications of noncovered benefits
- Cosmetic services and any related complications – surgery and any related complications, procedures, treatment, office visits and consultations and other services for cosmetic purposes.
- Correction of congenital malformations, except as required by state law for newborns, adopted children and children placed for adoption
- Costs paid by other organizations – costs/services customarily paid for by an employer, the government, biotechnical, pharmaceutical or medical device industry sources or other individuals or organizations
- Counseling of any kind, including but not limited to, nutritional counseling for control/prevention of oral disease and hygiene instructions
- Court-ordered services – except as stated in the benefit plan
- Dental implants or transfers and any related services
- Dental services which are not approved by the American Dental Association
- Enamel microabrasion
- Experimental or investigational services
- Fees other than for dentally necessary in-person, direct member services, except as stated in the benefit plan
- Free services
- General anesthesia and deep sedation
- Genetic and chromosomal testing and screening
- Gold foil restoration
- Government services – services provided at no charge through a governmental program or facility
- Inlays of any kind
- Inpatient or outpatient facility services – any services related to a member's facility visit, such as anesthesiologist charges or screening charges
- Major restorative and prosthodontic services performed on other than a permanent tooth
- Medications dispensed in a dentist's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturers' samples, dispensed to the member in a dentist's office.
- Non-dentally necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine dental necessity until after the services are rendered.
- Nitrous oxide gas, conscious sedation and other analgesias
- Occlusal guards for the treatment of temporomandibular joint syndrome
- Orthodontic services and tooth extractions which relate to those services, unless otherwise specifically covered under this benefit plan and listed as a covered service on the member's schedule page
- Over-the-counter items
- Personal comfort items
- Screening tests, except as stated in the benefit plan
- Services for idiopathic environmental intolerance
- Services and supplies that are not provided by a dentist – except dental prophylaxis and root planing performed by a licensed dental hygienist under the supervision and direction of a dentist
- Services from a family member – services that are provided by an eligible provider who is part of the member's immediate family. When a provider is also the covered person, services rendered by that provider for him/herself are also excluded from coverage.
- Services not requiring a licensed professional
- Services from ineligible providers
- Services paid for by other organizations
- Services and supplies provided after the member's coverage termination date
- Services provided prior to effective date
- Services related to or associated with noncovered services
- Services without a prescription when a prescription is required
- Telephonic and electronic consultations
- Therapy and treatment of the temporomandibular joint, orthognathic surgery, vestibuloplasty or ridge augmentation
- Training and education, including but not limited to, nutritional counseling for control of dental disease, tobacco counseling for control and prevention of oral disease and oral hygiene instructions
- Transportation services and travel expenses
- Workers' Compensation – illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election



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