Consumer's Right to Know About Health Plans in Rhode Island

BLUE CROSS DENTAL

DCR1 (09/02) and DCR2 (09/02)

BLUE CROSS & BLUE SHIELD OF RI

January 1, 2008

Consumer Disclosure

Single Service Plan Edition

Safe and Healthy Lives in Safe and Healthy Communities

Consumer Disclosure

Blue Cross Dental
Effective Date of Disclosure: January 2008

CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS
THE HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

WHY ARE YOU GETTING THIS INFORMATION?

- Knowing how Health Plans work helps you to be a better consumer.
- Meets State Law requiring Health Plans to disclose information.
- Provides information about your specific Health Plan.
- Informs you that a comprehensive list of all participating providers is available to you on the Health Plan Web Site (Hard copies available on request.)

Another document, the *Consumer's Guide to Health Plans in Rhode Island*, gives general information about health plans, including standard definitions of common terms, and is available upon request from Health Plan representatives. This document can also be found on the RI Department of Health Web Site, http://www.healthri.org/.

This Consumer Disclosure has been reviewed and approved by the Rhode Island Department of Health in accordance with R23-17.13 (Rules and Regulations for Certifying Health Plans). Requests for more information about Health Plan certification or consumer rights may be addressed to:

> Rhode Island Department of Health, Division of Health Services Regulation, 3 Capitol Hill, Providence, RI 02908-5097, Phone: 401 222-6015.

Q **Who can I contact at the Health Plan for information?** Representatives of this Health Plan are available to help you get the information you need. You can contact a Health Plan representative at:

A

Blue Cross & Blue Shield of Rhode Island
Customer Service Department
500 Exchange Street
Providence, RI 02903

Toll-free 1-800-527-7290; Telephone 401-831-7300; Fax: 401-459-2006;
TDD Number 401-831-2202; Internet www.BCBSRI.com.

These phone numbers can be used to: a) confirm the status of any provider; b) receive administrative or appeal process information; c) file a complaint; d) receive timely access information.

Para contactor a un representante que hable Espanol, llame a:
Departamiento de Servicios Para Miembros 1-800-527-7290.

Q **How does the Health Plan Review and approve covered services?** A Health Plan may review covered services that are recommended by providers to decide if the services are medically necessary. If the plan decides the service is not medically necessary, it will not pay. You and your provider can appeal the Health Plan's decision.

A

Covered dental services are listed in your official plan document. We recommend pre-authorization (prior authorization) for crowns, inlays/onlays, and surgical and non-surgical periodontics (treatment of gums), prosthodontics (bridges and dentures), implants, occlusal guards and orthodontics (braces) (if covered services under your plan). If you receive services from a participating dentist, the dentist will be responsible for obtaining pre-authorization for you.

You may appeal any review determination within one hundred eighty (180) days of receipt of the determination. We will review your appeal and respond to you within fifteen (15) days of receipt of the appeal request. If your appeal is denied, you may request a second appeal under the same terms as above. If your second appeal is denied, you may request an external appeal. An external appeal is reviewed by an agency that is not affiliated with us.

Q **What if I have an emergency?** An emergency is a problem that needs to be seen by a provider "right-away" to prevent permanent damage or death. Here's what this Health Plan wants you to do when you have an emergency health care problem, at home or out of state.

A

This dental plan covers minor emergency treatment to reduce or relieve acute dental pain (Consult your official plan document for a list of covered services). This dental plan does not cover hospital emergency room services; check your health plan to determine hospital emergency room coverage.

Q **What if I refuse referral to a participating provider:** When a specific covered service is recommended, Health Plans may send you to certain participating providers. If you refuse the referral and get the service from another provider, the Health Plan must tell you what effect it will have on payment.

A

This question is not applicable to this dental plan.

Q **Does the Health Plan require that I get a second opinion for any services? What if I want a second opinion?** In some cases the Health Plan may require a second opinion before it will pay for a covered service. Or you may just want a second opinion on a plan for diagnosis or treatment.

A

This question is not applicable to this dental plan.

Q **How does the Health Plan makes sure that my personal health information is protected and kept confidential?** In general, personal health information must be kept confidential (private) by a Health Plan, its employees and agencies it contracts with. Here's how the Health Plan makes sure that personal health information is protected.

A

We will release information about your health, treatment or condition to authorized doctors, health care providers, facilities, and insurers to coordinate your benefits and pay claims. Access to personally identifiable information is limited to persons who need to know. Our employees are instructed to keep such information confidential and sign a statement promising to do so. If an employee violates a member’s rights to privacy and confidentiality, this is grounds for employment termination.

Q **How am I protected from discrimination?** You have the right to be treated fairly and equally. Health Plans may not discriminate against you due to age, sex, religion, race or ethnic origin, disability, occupational status or any other characteristics protected by law.

A

You have the right to receive to receive benefits for all covered services determined by the plan to be medically necessary regardless of your race, religion, gender, sexual orientation, national origin, cultural background, disability, age, financial or occupational status, or membership in other protected groups.

Q **If I refuse treatment, will it affect my future treatment?** A Health Plan must tell you what effect it will have on future coverage if you refuse to be treated for any condition.

A

This dental plan does not restrict your right to refuse treatment. You may refuse treatment at your discretion. This refusal will not affect your access to future treatment, dental plan coverage, or payment for services.

Q **How does the Health Plan pay providers?** Your Health Plan must tell you about the kinds of financial arrangements it has with providers.

A

This dental plan is not capitated and does not contain other risk sharing arrangements.

Q **How is coverage renewed or canceled?**

A

This dental plan will be renewed automatically on its calendar anniversary date unless you choose another plan offered by your employer. Your coverage may only be cancelled if your employer fails to pay premiums for your group, if you cease to be eligible for coverage under the plan, or if fraud is documented.

Q **If I am covered by two or more health plans, what should I do?** If you or a family member is covered by two or more Health Plans, you may have to give information on your coverage to each Health Plan. This helps the Health Plans to arrange payments between the plans when you or a family member receive a service. Here's what this plan will ask you to tell them.

A

This dental plan will ask:
If you are the main subscriber or a dependent;
Your marital status, date of birth (yours and your spouse's) or length of time covered;
If you are a Medicare beneficiary;
If you are an active or inactive employee;
If a covered dependent is a student.
We may ask for other information not listed here if necessary to coordinate payments.

Health Benefits Required Under Rhode Island Law as of September 2000:
Health Maintenance Organizations (HMOs) and health insurers in Rhode Island are required by State law to provide enrollees with coverage for certain kinds of health care services. These laws do not apply to Medicare, Medicaid, ERISA self-funded plans or supplemental (e.g. Medigap) or single disease (e.g. Cancer coverage) health insurance policies (check with your workplace benefits administrator). These mandated benefits (see summary list in Consumer's Guide to Health Plans in RI) often apply only under certain circumstances, may be limited to participating providers, and are not always covered in full--other conditions and restrictions not mentioned here may apply. For more information about specific mandated benefits, contact your Health Plan representative or the Rhode Island Department of Business Regulation at 401-222-2223.

Covered Services at a Glance:
The information on the following pages shows you what services are covered under this Health Plan. This is only a summary. You may find complete information in the Official Plan Documents or contact the Health Plan Representative listed on the first page.

Single Service Health Plans (example: dental care, vision care) must provide you with standardized and easy-to-understand information about covered services -- including out-of-pocket costs, service limitations and other things you need to know. Single Service Health Plans can do this through general information materials or by using a special insert summary called "Covered Services at a Glance." For more complete information, read the Official Plan Documents or contact a Health Plan Representative. Using this information, you can compare:

- Health Plans
- Out-of-pocket costs
- Limits on services

Plan Options

Basic Blue Options

For groups with 3-9 employees

	Option 1	Option 2
Preventive/Diagnostic Services		
Oral exams	100%	100%
Cleanings (prophylaxis)	100%	100%
Fluoride treatment	—-	100%
X-rays	100%	100%
Minor Restorative Services		
Sealants	—	—
Fillings	*	*
Vital pulpotomy	—	—
Root canal therapy for anterior teeth	*	*
Root canal therapy for all permanent teeth	—	—
Denture or partial denture repairs	*	*
Rebasing/relining of full/partial dentures	*	*
Recementing crowns or bridges	—	—
Biopsies	*	*
Minor treatment for acute pain	*	*
Simple extractions	*	*
Oral surgery	—	—
General anesthesia	—	—
Space maintainers	—	—
Major Restorative Services		
Crowns, inlays, and onlays	—	—
Periodontics		
Periodontal maintenance and other non-surgical	—	—
Surgical periodontics	—	—
Prosthodontics		
Bridges, dentures	—	—
Orthodontics		
Braces to age 19	—	—

**Members can obtain these services from our Affinity Network dentists at a discount of up to 15%.*

Standard Provisions

Dependents: Spouse and unmarried children covered to age 19.

Benefit Limitations

Not all services are covered under all plans.
Exams: One initial or periodic exam per calendar year.
Cleanings: One cleaning per calendar year. Second cleaning per calendar year available at a discount with our Affinity Network providers.
X-rays: One bitewing series per calendar year; one full mouth set per 60 months; individual x-rays as needed.

Out-of-Network Coverage

Within Our Service Area: Our allowance, minus any applicable deductibles and/or coinsurance amounts.
Outside Our Service Area: Usual and customary, minus any applicable deductibles and/or coinsurance amounts.

Additional Coverage Available

Students: Must match student age under the medical plan.

Plan Options

Premier Blue

For groups with 3-9 employees

	Option 1	Option 2
Preventive/Diagnostic Services		
Oral exams	100%	100%
Cleanings (prophylaxis)	100%	100%
Fluoride Treatment	100%	100%
X-rays	100%	100%
Minor Restorative Services		
Sealants	100%	100%
Fillings	100%	100%
Vital pulpotomy	100%	100%
Root canal therapy for anterior teeth	100%	100%
Root canal therapy for all permanent teeth	—	50%
Denture or partial denture repairs	100%	100%
Rebasing/relining of full/partial dentures	100%	100%
Recementing crowns or bridges	100%	100%
Biopsies	100%	100%
Minor treatment for acute pain	100%	100%
Simple extractions	100%	100%
Oral surgery	—	50%
General anesthesia	—	50%
Space maintainers	—	50%
Major Restorative Services		
Crowns, inlays, and onlays	—	50%
Periodontics		
Periodontal maintenance and other non-surgical periodontic procedures	—	50%
Surgical periodontics	—	50%
Prosthodontics		
Bridges, dentures	—	—
Orthodontics		
Braces to age 19	—	—

Standard Provisions

Dependents: Spouse and unmarried children covered to age 19.
Calendar Year Deductible: $50 per member applicable to all services with a coinsurance.
Calendar Year Maximum: $1,200 per member.

Benefit Limitations

Not all services are covered under all plans.
Exams: One initial or periodic exam per calendar year.
Cleanings: Two cleanings per calendar year.
Fluoride Treatment: One treatment per calendar year for eligible dependents to age 19.
X-rays: One bitewing series per calendar year; one full mouth set per 36 months; individual x-rays as needed.
Fillings: Amalgam and composite fillings as needed; recementing of crowns and inlays.
Sealants: One treatment every three years to unfilled/undecayed permanent molars for dependents ages 6-13.
Simple Extractions: Removal of erupted teeth not requiring surgery.
Biopsies: Biopsy and examination of hard or soft oral tissue when not covered by medical plan.
Minor Treatment for Acute Pain: Minor treatment to relieve acute pain.
Anterior Root Canal Therapy: Covered for front (anterior) teeth only.
Vital Pulpotomy: Vital pulpotomy for eligible dependents under age 11.
Root Canal Therapy: Root canal therapy procedures, including pulpotomy and pulp capping, for all permanent teeth. Final restoration excluded.
Oral Surgery: Surgical extractions and other eligible oral surgical procedures not covered under any medical plan. Includes general anesthesia for covered surgical procedures.
Non-surgical Periodontics: Non-surgical procedures for the treatment of tissues supporting the teeth. Preauthorization is recommended.
Surgical Periodontics: Includes osseous surgery; gingivectomies; gingival curretage; soft tissue grafts, and crown lengthening.
Space Maintainers: When not made of cast precious metals.
Crowns/Inlays/Onlays: Crowns, inlays and onlays which are not part of a fixed bridge. Preauthorization is recommended.
Denture Repairs: Includes replacement of teeth, reattachment or replacement of clasps and facings, relinings or adjustments, repair to broken dentures.

Out-of-Network Coverage

Within Our Service Area: Our allowance, minus any applicable deductibles and/or coinsurance amounts.
Outside Our Service Area: Usual and customary, minus any applicable deductibles and/or coinsurance amounts.

Additional Coverage Available

Students: Students to age 23, 24, 25, or 26, enrolled at an accredited institution.

Plan Options

Premier Blue

For groups with 10-25 employees

	Option 1	Option 2	Option 3
Preventive/Diagnostic Services			
Oral exams	100%	100%	100%
Cleanings	100%	100%	100%
Fluoride treatment	100%	100%	100%
X-rays	100%	100%	100%
Minor Restorative Services			
Sealants	100%	100%	100%
Fillings	100%	100%	100%
Vital pulpotomy	100%	100%	100%
Root canal therapy for anterior teeth	100%	100%	100%
Root canal therapy for all permanent teeth	—	50%	50%
Denture or partial denture repairs	100%	100%	100%
Rebasing/relining of full/partial dentures	100%	100%	100%
Recementing crowns or bridges	100%	100%	100%
Biopsies	100%	100%	100%
Minor treatment for acute pain	100%	100%	100%
Simple extractions	100%	100%	100%
Oral surgery	—	50%	50%
General anesthesia	—	50%	50%
Space maintainers	—	50%	50%
Major Restorative Services			
Crowns, inlays, and onlays	—	50%	50%
Periodontics			
Periodontal maintenance and other non-surgical	—	50%	50%
Surgical periodontics	—	50%	50%
Prosthodontics			
Bridges, dentures	—	—	50%
Orthodontics			
Braces to age 19	—	—	—

Standard Provisions

Dependents: Spouse and unmarried children covered to age 19.

Calendar Year Deductible: 50 per member applicable to all services with a coinsurance.

Calendar Year Maximum: $1,200 per member.

Benefit Limitations

Not all services are covered under all plans.

Exams: One initial or periodic exam per calendar year.

Cleanings: Two cleanings per calendar year.

Fluoride Treatment: One treatment per calendar year for eligible dependents to age 19.

X-rays: One bitewing series per calendar year; one full mouth set per 36 months; individual x-rays as needed.

Fillings: Amalgam and composite fillings as needed; recementing of crowns and inlays.

Sealants: One treatment every three years to unfilled/undecayed permanent molars for dependents ages 6-13.

Simple Extractions: Removal of erupted teeth not requiring surgery.

Biopsies: Biopsy and examination of hard or soft oral tissue when not covered by medical plan.

Minor Treatment for Acute Pain: Minor treatment to relieve acute pain.

Anterior Root Canal Therapy: Covered for front (anterior) teeth only.

Vital Pulpotomy: Vital pulpotomy for eligible dependents under age 11.

Root Canal Therapy: Root canal therapy, including pulpotomy and pulp capping, for all permanent teeth. Final restoration excluded.

Oral Surgery: Surgical extractions and other eligible oral surgical procedures not covered under any medical plan. Includes general anesthesia for covered surgical procedures.

Non-surgical Periodontics: Non-surgical procedures for the treatment of tissues supporting the teeth. Preauthorization is recommended.

Surgical Periodontics: Includes osseous surgery; gingivectomies; gingival curretage; soft tissue grafts and crown lengthening.

Space Maintainers: When not made of cast precious metals.

Crowns/Inlays/Onlays: Crowns, inlays, and onlays which are not part of a fixed bridge. Preauthorization is recommended.

Bridges and Dentures: Construction of bridges, partial, and complete dentures. Preauthorization is recommended.

Denture Repairs: Includes replacement of teeth, reattachment or replacement of clasps and facings, relinings or adjustments, repair to broken dentures.

Out-of-Network Coverage

Within Our Service Area: Our allowance, minus any applicable deductibles and/or coinsurance amounts.

Outside Our Service Area: Usual and customary, minus any applicable deductibles and/or coinsurance amounts.

Additional Coverage Available

Students: Students to age 23, 24, 25, or 26, enrolled at an accredited institution.

Plan Options

Premier Blue

For groups with 26 or more employees

	Option 1	Option 2	Option 3	Option 4	Option 5
Preventive/Diagnostic Services					
Oral exams	100%	100%	100%	100%	100%
Cleanings (prophylaxis)	100%	100%	100%	100%	100%
Fluoride Treatment	100%	100%	100%	100%	100%
X-rays	100%	100%	100%	100%	100%
Minor Restorative Services					
Sealants	100% by rider	100% by rider	100% by rider	100% by rider	100% by rider
Fillings	100%	100%	100%	100%	100%
Vital pulpotomy	100%	100%	100%	100%	100%
Root canal therapy for anterior teeth	100%	100%	100%	100%	100%
Root canal therapy for all permanent teeth	—	100%	100%	100%	100%
Denture or partial denture repairs	100%	100%	100%	100%	100%
Rebasing/relining of full/partial dentures	100%	100%	100%	100%	100%
Recementing crowns or bridges	100%	100%	100%	100%	100%
Biopsies	100%	100%	100%	100%	100%
Minor treatment for acute pain	100%	100%	100%	100%	100%
Simple extractions	100%	100%	100%	100%	100%
Oral surgery	—	100%	100%	100%	100%
General anesthesia	—	100%	100%	100%	100%
Space maintainers	—	100%	100%	100%	100%
Major Restorative Services					
Crowns, inlays, and onlays	—	100%	100%	100%	100%
Periodontics					
Periodontal maintenance and other non-surgical periodontic procedures	—	50%	50%	50%	50%
Surgical periodontics	—	50%	50%	50%	50%
Prosthodontics					
Bridges, dentures	—	—	50%	—	50%
Orthodontics					
Braces to age 19	—	—	—	50%	50%

Standard Provisions

Dependents: Spouse and unmarried children covered to age 19.
Calendar Year Maximum: $1,200 per member.

Benefit Limitations

Not all services are covered under all plans. See other side for available benefits.
Exams: One initial or periodic exam per calendar year.
Cleanings: Two cleanings per calendar year.
Fluoride Treatment: One treatment per calendar year for eligible dependents to age 19.
X-rays: One bitewing series per calendar year; one full mouth set per 36 months;
individual x-rays as needed.
Fillings: Amalgam and composite fillings as needed; recementing of crowns and inlays.
Sealants: One treatment every three years to unfilled/undecayed permanent molars for dependents ages 6-13.
Simple Extractions: Removal of erupted teeth not requiring surgery.
Biopsies: Biopsy and examination of hard or soft oral tissue when not covered by medical plan.
Minor Treatment for Acute Pain: Minor treatment to relieve acute pain.
Anterior Root Canal Therapy: Covered for front (anterior) teeth only.
Vital Pulpotomy: Vital pulpotomy for eligible dependents under age 11.
Root Canal Therapy: Root canal therapy procedures, including pulpotomy and pulp capping, for all permanent teeth.
Final restoration excluded.
Oral Surgery: Surgical extractions and other eligible oral surgical procedures not covered under any medical plan.
Includes general anesthesia for covered surgical procedures.
Non-surgical Periodontics: Non-surgical procedures for the treatment of tissues supporting the teeth. Preauthorization is recommended.
Surgical Periodontics: Includes osseous surgery; gingivectomies; gingival curretage; soft tissue grafts, and crown lengthening.
Space Maintainers: When not made of cast precious metals.
Crowns/Inlays/Onlays: Crowns, inlays and onlays which are not part of a fixed bridge. Preauthorization is recommended.
Denture Repairs: Includes replacement of teeth, reattachment or replacement of clasps and facings, relinings
or adjustments, repair to broken dentures.

Out-of-Network Coverage

Within Our Service Area: Our allowance, minus any applicable deductibles and/or coinsurance amounts.
Outside Our Service Area: Usual and customary, minus any applicable deductibles and/or coinsurance amounts.

Additional Coverage Available

Students: Students to age 23, 24, 25, or 26, enrolled at an accredited institution.

Plan Options

Advantage Blue

For groups with 3-9 employees

	Option 1	Option 2
Preventive/Diagnostic Services		
Oral exams	100%	100%
Cleanings (prophylaxis)	100%	100%
Fluoride treatment	100%	100%
X-rays	100%	100%
Minor Restorative Services		
Sealants	80%	80%
Fillings	80%	80%
Vital pulpotomy	80%	80%
Root canal therapy for anterior teeth	80%	80%
Root canal therapy for all permanent teeth	80%	80%
Denture or partial denture repairs	—	—
Rebasing/relining of full/partial dentures	—	—
Recementing crowns or bridges	80%	80%
Biopsies	80%	80%
Minor treatment for acute pain	80%	80%
Simple extractions	80%	80%
Oral surgery	80%	80%
General anesthesia	80%	80%
Space maintainers	80%	80%
Major Restorative Services		
Crowns, inlays, and onlays	—	50%
Periodontics		
Periodontal maintenance and other non-surgical	80%	80%
Surgical periodontics	—	—
Prosthodontics		
Bridges, dentures	—	—
Orthodontics		
Braces to age 19	—	—

Standard Provisions

Multi-stage procedures: Not covered if treatment commenced prior to effective date if group is new to dental.

Dependents: Spouse and unmarried children covered to age 19.

Calendar Year Deductible: None - or - $50 per member applicable to all services with a coinsurance.

Calendar Year Maximum: $1,500 per member.

Benefit Limitations

Exams: One initial or periodic exam per calendar year.

Cleanings: One cleaning every six months.

Fluoride Treatment: One treatment per calendar year for eligible dependents to age 19.

X-rays: One bitewing series per calendar year; one full mouth set per 60 months; individual x-rays as needed.

Fillings: Amalgam and composite fillings as needed; recementing of crowns and inlays.

Sealants: One treatment every three years to unfilled/undecayed permanent molars for dependents ages 6-13.

Simple Extractions: Removal of erupted teeth not requiring surgery.

Biopsies: Biopsy and examination of hard or soft oral tissue when not covered by medical plan.

Minor Treatment for Acute Pain: Minor treatment to relieve acute pain.

Anterior Root Canal Therapy: Covered for front (anterior) teeth only.

Vital Pulpotomy: Vital pulpotomy for eligible dependents under age 11.

Root Canal Therapy: Root canal therapy, including pulpotomy and pulp capping, for all permanent teeth. Final restoration excluded.

Oral Surgery: Surgical extractions and other eligible oral surgical procedures not covered under any medical plan. Includes general anesthesia for covered surgical procedures.

Non-surgical Periodontics: Non-surgical procedures for the treatment of tissues supporting the teeth. Preauthorization is recommended.

Surgical Periodontics: Includes osseous surgery; gingivectomies; gingival curretage; soft tissue grafts and crown lengthening.

Space Maintainers: When not made of cast precious metals.

Crowns/Inlays/Onlays: Crowns, inlays, and onlays which are not part of a fixed bridge. Preauthorization is recommended.

Out-of-Network Coverage

Within Our Service Area: 75% of our allowance, minus any applicable deductibles and/or coinsurance amounts.

Outside Our Service Area: Usual and customary, minus any applicable deductibles and/or coinsurance amounts.

Additional Coverage Available

Students: Students to age 23, 24, 25, or 26, enrolled at an accredited institution.

Plan Options

Advantage Blue

For groups with 10-25 employees

	Option 1	Option 2	Option 3
Preventive/Diagnostic Services			
Oral exams	100%	100%	100%
Cleanings	100%	100%	100%
Fluoride treatment	100%	100%	100%
X-rays	100%	100%	100%
Minor Restorative Services			
Sealants	80%	80%	80%
Fillings	80%	80%	80%
Vital pulpotomy	80%	80%	80%
Root canal therapy for anterior teeth	80%	80%	80%
Root canal therapy for all permanent teeth	80%	80%	80%
Denture or partial denture repairs	—	—	50%
Rebasing/relining of full/partial dentures	—	—	50%
Recementing crowns or bridges	80%	80%	80%
Biopsies	80%	80%	80%
Minor treatment for acute pain	80%	80%	80%
Simple extractions	80%	80%	80%
Oral surgery	80%	80%	80%
General anesthesia	80%	80%	80%
Space maintainers	80%	80%	80%
Major Restorative Services			
Crowns, inlays, and onlays	—	50%	50%
Periodontics			
Periodontal maintenance and other non-surgical periodontic procedures	80%	80%	80%
Surgical periodontics	—	—	50%
Prosthodontics			
Bridges, dentures	—	—	50%
Orthodontics			
Braces to age 19	—	—	—

Standard Provisions

Multi-stage Procedures: Not covered if treatment commenced prior to effective date if group is new to dental coverage.

Dependents: Spouse and unmarried children covered to age 19.

Calendar Year Deductible: None - or - $50 per member applicable to all services with a coinsurance.

Calendar Year Maximum: $1,500 per member.

Benefit Limitations

Not all services are covered under all plans.

Exams: One initial or periodic exam per calendar year.

Cleanings: One cleaning every six months.

Fluoride Treatment: One treatment per calendar year for eligible dependents to age 19.

X-rays: One bitewing series per calendar year; one full mouth set per 60 months; individual x-rays as needed.

Fillings: Amalgam and composite fillings as needed; recementing of crowns and inlays.

Sealants: One treatment every three years to unfilled/undecayed permanent molars for dependents ages 6-13.

Simple Extractions: Removal of erupted teeth not requiring surgery.

Biopsies: Biopsy and examination of hard or soft oral tissue when not covered by medical plan.

Minor Treatment for Acute Pain: Minor treatment to relieve acute pain.

Root Canal Therapy: Root canal therapy, including pulpotomy and pulp capping, for all permanent teeth. Final restoration excluded.

Anterior Root Canal Therapy: Covered for front (anterior) teeth only.

Vital Pulpotomy: Vital pulpotomy for eligible dependents under age 11.

Oral Surgery: Surgical extractions and other eligible oral surgical procedures not covered under any medical plan. Includes general anesthesia for covered surgical procedures.

Non-surgical Periodontics: Non-surgical procedures for the treatment of tissues supporting the teeth. Preauthorization is recommended.

Surgical Periodontics: Includes osseous surgery; gingivectomies; gingival curretage; soft tissue grafts and crown lengthening.

Space Maintainers: When not made of cast precious metals.

Crowns/Inlays/Onlays: Crowns, inlays, and onlays which are not part of a fixed bridge. Preauthorization is recommended.

Bridges, and Dentures: Construction of bridges, partial, and complete dentures. Preauthorization is recommended.

Denture Repairs: Includes replacement of teeth, reattachment, or replacement of clasps and facings, relinings or adjustments, repair to broken dentures.

Out-of-Network Coverage

Within Our Service Area: 75% of our allowance, minus any applicable deductibles and/or coinsurance amounts.

Outside Our Service Area: Usual and customary, minus any applicable deductibles and/or coinsurance amounts.

Additional Coverage Available

Students: Students to age 23, 24, 25, or 26, enrolled at an accredited institution.

Plan Options

Advantage Blue

For groups with 26 or more employees

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Preventive/Diagnostic Services						
Oral exams	100%	100%	100%	100%	100%	100%
Cleanings (prophylaxis)	100%	100%	100%	100%	100%	100%
Fluoride Treatment	100%	100%	100%	100%	100%	100%
X-rays	100%	100%	100%	100%	100%	100%
Minor Restorative Services						
Sealants	80%	80%	80%	80%	80%	80%
Fillings	80%	80%	80%	80%	80%	80%
Vital pulpotomy	80%	80%	80%	80%	80%	80%
Root canal therapy for anterior teeth	80%	80%	80%	80%	80%	80%
Root canal therapy for all permanent teeth	80%	80%	80%	80%	80%	80%
Denture or partial denture repairs	—	—	50%	—	—	50%
Rebasing/relining of full/partial dentures	—	—	50%	—	—	50%
Recementing crowns or bridges	80%	80%	80%	80%	80%	80%
Biopsies	80%	80%	80%	80%	80%	80%
Minor treatment for acute pain	80%	80%	80%	80%	80%	80%
Simple extractions	80%	80%	80%	80%	80%	80%
Oral surgery	80%	80%	80%	80%	80%	80%
General anesthesia	80%	80%	80%	80%	80%	80%
Space maintainers	80%	80%	80%	80%	80%	80%
Major Restorative Services						
Crowns, inlays, and onlays	—	50%	50%	—	50%	50%
Periodontics						
Periodontal maintenance and other non-surgical periodontic procedures	80%	80%	80%	80%	80%	80%
Surgical periodontics	—	—	50%	—	—	50%
Prosthodontics						
Bridges, dentures	—	—	50%	—	—	50%
Orthodontics						
Braces to age 19	—	—	—	50%	50%	50%

Standard Provisions

Multi-stage procedures: Not covered if treatment commenced prior to effective date if group is new to dental coverage.
Dependents: Spouse and unmarried children covered to age 19.
Calendar Year Deductible: None - or - $50 per member applicable to all services with a coinsurance.
Calendar Year Maximum: $1,500 per member.
Orthodontic Lifetime Maximum: $1,500 per dependent.

Benefit Limitations

Not all services are covered under all plans.

Exams: One initial or periodic exam per calendar year.
Cleanings: One cleaning every six months.
Fluoride Treatment: One treatment per calendar year for eligible dependents to age 19.
X-rays: One bitewing series per calendar year; one full mouth set per 60 months; individual x-rays as needed.
Fillings: Amalgam and composite fillings as needed; recementing of crowns and inlays.
Sealants: One treatment every three years to unfilled/undecayed permanent molars for dependents ages 6-13.
Simple Extractions: Removal of erupted teeth not requiring surgery.
Biopsies: Biopsy and examination of hard or soft oral tissue when not covered by medical plan.
Minor Treatment for Acute Pain: Minor treatment to relieve acute pain.
Root Canal Therapy: Root canal therapy, including pulpotomy and pulp capping, for all permanent teeth. Final restoration excluded.
Anterior Root Canal Therapy: Covered for front (anterior) teeth only.
Vital Pulpotomy: Vital pulpotomy for eligible dependents under age 11.
Oral Surgery: Surgical extractions and other eligible oral surgical procedures not covered under any medical plan. Includes general anesthesia for covered surgical procedures.
Non-surgical Periodontics: Non-surgical procedures for the treatment of tissues supporting the teeth. Preauthorization is recommended.
Surgical Periodontics: Includes osseous surgery; gingivectomies; gingival curretage; soft tissue grafts, and crown lengthening.
Space Maintainers: When not made of cast precious metals.
Crowns/Inlays/Onlays: Crowns, inlays, and onlays which are not part of a fixed bridge. Preauthorization is recommended.
Bridges and Dentures: Construction of bridges, partial, and complete dentures. Preauthorization is recommended.
Denture Repairs: Includes replacement of teeth, reattachment or replacement of clasps and facings, relinings or adjustments, repair to broken dentures.
Orthodontics: Braces and related care, up to the lifetime maximum, for dependent children under age 19. The orthodontic lifetime maximum is separate from the annual dollar maximum for other services. Preauthorization is recommended.

Out-of-Network Coverage

Within Our Service Area: 75% of our allowance, minus any applicable deductibles and/or coinsurance amounts.
Outside Our Service Area: Usual and customary, minus any applicable deductibles and/or coinsurance amounts.

Additional Coverage Available

Students: Students to age 23, 24, 25, or 26, enrolled at an accredited institution.
Implants: Surgical placement or removal covered at 50%. Replacement covered only if existing implant is more than 5 years old. Lifetime maximum of $3,500 per member. Preauthorization is recommended. Must have basic, major restorative and prosthodontic coverage and 50 or more employees.