

# Blue Dental Plus<sup>SM</sup> Premier

Blue Cross and Blue Shield of Texas (*herein called "BCBSTX, We, Us, Our"*)

## REQUIRED OUTLINE OF COVERAGE

**I. Read Your Policy Carefully.** This Outline of Coverage provides a very brief description of some important features of Your Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of You, Your Physician or Professional Other Provider and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

**II.** The Policy is designed to provide You with coverage for diagnostic and preventive dental care, as well as almost every form of specialty dental treatment.

Coverage is provided for the Benefits outlined in Paragraph III. The Benefits described in Paragraph III may be limited by Paragraph IV.

This Policy will pay without regard to any Medicare, Medicare Advantage or Medicaid coverage.

**III. Benefits.** Your dental care Benefits are highlighted below.

- A. **Benefit Period** – Your Benefit Period is a Calendar Year (begins January 1 and ends December 31).
- B. **Deductible** – The Calendar Year Deductible will be subtracted once during each Calendar Year from each Participant’s total Eligible Expenses.

Benefits	Deductible Amount	
Calendar Year Deductibles	Contracting Dentist	Non-Contracting Dentist
• Individual	\$50	\$50

C. **Covered Services** – All Benefits are based upon the Allowable Amount, which is the amount determined by BCBSTX as the maximum amount eligible for payment of Benefits. A Contracting Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a Non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely that the Non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses. A 12-month waiting period may apply to some services.

The Deductibles, Coinsurance Amount, Annual Maximum and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

Covered Services	Benefit Payable
Diagnostic Evaluations (Deductible waived)	100%
Preventive Services (Deductible waived)	100%
Diagnostic Radiographs (Deductible waived)	100%
Miscellaneous Preventive Services	80%
Basic Restorative Services	80%
Non-Surgical Extractions	80%
Non-Surgical Periodontal Services	80%
Adjunctive Services	80%
Endodontic Services	50%
Oral Surgery Services	50%
Surgical Periodontal Services*	50%
Major Restorative Services*	50%
Prosthodontic Services*	50%
Miscellaneous Restorative and Prosthodontic Services*	50%
Orthodontics	Not Covered
<b>Benefit Period Maximum</b>	<b>\$2,000</b>

\*12 Month Benefit Waiting Period applies.

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#### Hearing Care

Hearing Care per Benefit Period	Plan Pays	You Pay
Annual Routine Examination	100%	\$0
Hardware Discounts	Generally 30%	Remaining Balance

#### IV. Limitations and Exclusions

These general Limitations and Exclusions apply to all services described in the dental Policy. Dental coverage is limited to services provided by a Dentist, or a dental auxiliary licensed to perform services covered under this dental Policy.

##### Important Information About Your Dental Benefits

- **Dental Procedures Which Are Not Dentally Necessary**

**Please note that in order to provide You with dental care Benefits at a reasonable cost, this Policy provides Benefits only for those covered services for eligible dental treatment that are determined by BCBSTX to be Dentally Necessary.**

No Benefits will be provided for procedures which are not Dentally Necessary. Dentally Necessary generally means that a specific procedure provided to You is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to You, as determined by BCBSTX.

The fact that Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Dentally Necessary.

- **Care By More Than One Dentist**

If You change Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if You had stayed with the same Dentist until Your treatment was completed. There will be no duplication of Benefits.

- **Alternate Benefits**

In all cases in which there is more than one covered procedure or Course of Treatment possible to treat a covered dental condition, the Benefit will be based upon the least costly covered procedure or Course of Treatment, as determined by BCBSTX. If the Participant requests or accepts the more costly service, the Participant is responsible for expenses that exceed the amount covered for the least costly service.

When two or more services are submitted and the services are considered part of the same service, We will pay the most comprehensive service as determined by BCBSTX.

When two or more services are submitted on the same day and the services are considered mutually exclusive (one service contradicts the need for the other service), We will pay for the service that represents the final treatment as determined by BCBSTX.

If You and Your Dentist decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the least costly Course of Treatment procedures for dental services, as determined by Us.

- **Non-Compliance with Prescribed Care**

Any additional treatment and resulting liability which is caused by the lack of a Participant's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Participant.

### **Exclusions — What Is Not Covered**

No Benefits will be provided under this Policy for:

- Services or supplies not specifically listed as a covered service, or when they are related to a non-covered service;
- Amounts which are in excess of the Allowable Amount, as determined by BCBSTX;
- Dental services treatment of congenital or developmental malformation or services performed for cosmetic purposes including but not limited to bleaching teeth and grafts to improve aesthetics;
- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders;
- Dental services or appliances to increase vertical dimension;
- Services and supplies for any illness or injury suffered after the Participant's Effective Date as a result of war or any act of war, declared or undeclared, or while on active or reserve duty in the armed forces of any country or international authority;
- Services or supplies that do not meet accepted standards of dental practice;
- Experimental/Investigational and/or Unproven services and supplies and all related services and supplies;
- Hospital and ancillary charges;
- Services or supplies for which You are not required to make payment or would have no legal obligation to pay if You did not have this or similar coverage;
- Services or supplies for which "discounts" or waiver of Deductible or coinsurance amounts are offered;
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable;
- Services or supplies received for behavior management or consultation purposes;
- Any services or supplies provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employment whether or not Benefits are, or could upon proper claim be, provided under the Workers' Compensation law;
- Charges for nutritional, tobacco or oral hygiene counseling;
- Charges for local, state, or territorial taxes on dental services or procedures;
- Charges for the administration of infection control procedures as required by local, state, or federal mandates;
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional appliances;
- Charges for telephone consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays;

- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, or preparations or medicament carriers;
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques;
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers;
- Services performed due to congenitally missing tooth or teeth;
- Gold foil restorations;
- Restorative procedures for the purpose of altering vertical dimension of occlusion, or treatment of attrition, abfraction, abrasion, and erosion;
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to Your Effective Date under this Policy; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after Your Effective Date;
- Any services, treatments or supplies included as covered services under other hospital, medical and/or surgical coverage;
- Case presentations or detailed and extensive treatment planning when billed for separately;
- Charges for occlusion analysis or occlusal adjustments;
- Anatomical crown exposure;
- Comprehensive periodontal evaluations or problem-focused evaluations if covered services are rendered on the same date as any other oral evaluation and by the same Dentist;
- Tests and oral pathology procedures, or for re-evaluations;
- Radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction;
- Chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy;
- Local anesthesia or other drugs or medicaments and/or their application;
- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist;
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal;
- Endodontic therapy if you discontinue endodontic treatment;
- Surgical services related to a congenital malformation;
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan;
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
- Treatment of fractures of facial bones;
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands or ducts;
- Reduction of dislocation, or excision of the temporomandibular joints;
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration;
- Restoration of occlusion or incisal edges due to bruxism or harmful habits;
- Treatment to replace teeth which were missing prior to the Effective Date; and
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

BCBSTX may, without waiving these exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the exclusions listed above. If it is later determined that the care and services are excluded from the Participant's coverage, We will be entitled to recover the amount we have allowed for Benefits under this Policy. The Participant must provide BCBSTX with all documents We need to enforce its rights under this provision.

## V. Renewability

This Policy is renewable at the option of the Subscriber unless terminated as discussed below.

If Your coverage this Dental Policy is terminated for any reason BCBSTX will provide You with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage.

## Termination by Blue Cross and Blue Shield of Texas

The coverage of the Subscriber under this Policy will terminate on the earliest of the following dates:

- a. On the last day of the last period for which the premium for this Policy has been paid, subject to the grace period provided in the section entitled **Premiums** of this Policy; or
- b. On the last day of any Policy Month upon written request for termination of this Policy made by You and received prior thereto; or
- c. On the date Your coverage for dental insurance cancels or terminates; or
- d. On the Policy Effective Date for fraudulent or intentional misrepresentation of a material fact; or
- e. On Your date of death; or
- f. On the date following 90 days advance notice by Us to the Subscriber, but only if We are terminating all other this particular type of individual coverage for all Subscribers provided that We act uniformly without regard to any health-status related factor of covered individuals.

## VI. Premiums

- A. The initial premium rate for Your Plan selection under this Policy is \$\_\_\_\_\_. Enclose the premium with your application.

Premiums are payable monthly or quarterly and are due on the first day of each Policy Month.

The initial premium is required to place the insurance in force. There is no insurance unless the first month's premium is paid.

When You renew BCBSTX coverage or reenroll by selecting a new product, You will need to be current on Your premium payments. Any past due premium payments for coverage We provided will be due at the beginning of the new plan year in addition to current premium charges. New coverage will not be effective until all such payments are made.

### **Premium Discount**

You may be eligible for a discount if You are enrolled in a BCBSTX Medicare Supplement policy. The discount is 5%.

- B. **Grace Period**

A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the Policy shall continue in force shall continue in force, subject to its termination in accordance with the provisions hereof.