Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

WESTERN MICHIGAN UNIVERSITY
Group# 007005281/0048
Dental Coverage
Effective Date: On or after January 2020
Benefits-at-a-glance for DENTAL/VISION ONLY

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

**A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices is two dentist locations.*

Blue Par Select℠ arrangement- Most non-PPO(out-of-network) dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services, and members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Benefits	Coverage
Deductible • Applies to Class II and Class III services only	$30 per member limited to a maximum of $60 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	10%
• Class III services	50%
• Class IV services	40%
Dollar maximums • Annual maximum for Class I, II and III services	$2,500 per member
• Lifetime maximum for Class IV services	$2,500 per member

ADM DC26MEVIS;ADM PLANYR JAN;ASCMOD 8886 VIS;ASCMOD 8887 DEN;BLUE DENTAL;BLUE VISION;BVC $10;BVFLE;CDC-DC 26-ME;DO-PPO;PKE39

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Prophylaxis (cleaning)	100% of approved amount **Note:** Twice per calendar year
Sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	90% of approved amount after deductible **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	90% of approved amount after deductible **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays and inlays restorations - permanent teeth - for members age 12 and older	90% of approved amount after deductible **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	90% of approved amount after deductible **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	90% of approved amount after deductible
Root canal treatment	90% of approved amount after deductible **Note:** Once every 12 months
Scaling and root planing	90% of approved amount after deductible **Note:** Once every 24 months per quadrant
Full mouth occlusal adjustments	90% of approved amount after deductible
Occlusal biteguards	90% of approved amount after deductible **Note:** Once every 12 months
General anesthesia or IV sedation	90% of approved amount after deductible **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	90% of approved amount after deductible **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	90% of approved amount after deductible **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	90% of approved amount after deductible **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount after deductible **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount after deductible **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount after deductible **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
Crowns - permanent teeth - for members age 12 and older	50% of approved amount after deductible **Note:** Once every 60 months per tooth

Class IV services

Benefits	Coverage
Minor treatment for tooth guidance appliances	60% of approved amount
Minor treatment to control harmful habits	60% of approved amount
Interceptive and comprehensive orthodontic treatment	60% of approved amount
Post-treatment stabilization	60% of approved amount
Cephalometric film (skull) and diagnostic photos	60% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

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Vision Coverage
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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$10 copay	$10 copay applies to charge
Prescription glasses (lenses and/or frames)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Member responsible for difference between benefit maximum and provider's charge
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Member responsible for difference between benefit maximum and provider's charge
Annual benefit maximum	BCBSM will pay **up to a benefit maximum of $400** per member, whether obtained from a VSP or Non-VSP provider in any period of 24 consecutive months for standard lenses, frames and contact lenses. You are responsible for any provider charges over the $400 amount.	

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$10 copay	Reimbursement up to $50 less $10 copay (member responsible for any difference)
	One eye exam in any period of 24 **consecutive** months	

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Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)
	One frame in any period of 24 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)
	Contact lenses up to the benefit maximum in any period of 24 consecutive months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)
	Contact lenses up to the benefit maximum in any period of 24 consecutive months	