Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE

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, you agree 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.

Dear Subscriber:

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 Dental[SM] could help you improve your overall health, too.

We encourage you to use your Blue Dental benefits. This certificate, along with any riders or schedule of benefits 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 check our website at http://www.bcbsm.com/.

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

We're pleased that you're a Blue Dental subscriber, and we look forward to serving you for many years.

Sincerely,

Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

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 & 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**. Business hours: 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.

Your certificate refers to you as the **subscriber** because the contract is in your name.

The term **member** refers to either you or one of your eligible dependents who receives dental services. Your eligible dependents are those listed on your application.

Table of Contents

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
- **CONTINUATION OF BENEFITS (COBRA)**

ELIGIBILITY

You will need to complete an application for coverage.

We will review your application to determine if you and the people you list on it are eligible for coverage. Our decision will be based on the terms in this certificate and our underwriting policies in effect at the time you apply for coverage.

If you or anyone applying for coverage on your behalf commits fraud or intentionally lies about a material fact when filling out your application, your coverage may be rescinded. See "*Rescission*" on page 5.

Who Is Eligible to Receive Benefits

- You
- Dependents listed on your contract:
  - Your spouse
  - Your children

A person who marries a member who already has coverage as a surviving spouse is not eligible for benefits.

Children listed on your contract are covered through the end of the calendar year in which they turn age 26 as long as you are covered under this certificate. The children must be related to you by:

- Birth
- Marriage
- Legal adoption
- Legal guardianship

Your child's spouse and your grandchildren are not eligible for coverage under this certificate.

After the end of the year in which your child turns 26, they will be removed from your contract. Your child may be eligible for their own contract through COBRA or a BCBSM individual plan. To learn more about COBRA, see the *Continuation of Benefits* subsection at the end of Section 1.

Some benefits change based on your age. Please refer to the *Coverage for Dental Services* section to determine what benefits apply to you and your dependent children.

Who Is Eligible to Receive Benefits (continued)

Disabled Unmarried Children

Disabled, unmarried children may remain covered after they turn age 26 if all of the following apply:

- They cannot support themselves due to a diagnosis of:
  - A physical disability or
  - A developmental disability
- They are dependent on you for support and maintenance.

Your employer must send us a physician's certification proving that the child is disabled. We must receive it within 31 days after the end of the year in which the child turns age 26. We will decide if the child meets the requirements for coverage.

You may also request group coverage for yourself or your dependents within 60 days after your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.

A dependent, whether or not they are disabled, who becomes ineligible for coverage under this contract may be eligible for their own contract. Contact Customer Service for information about what plans are available. COBRA coverage (if applicable) may also be available.

WHEN YOU CAN ENROLL

- During the annual open enrollment period
- Up to 31 days after a qualifying event, as defined by federal law
- At other times of the year, as allowed by federal law

WHEN YOUR BENEFITS BEGIN

Unless your plan has a waiting period, covered benefits and services are available on the effective date of your contract.

CHANGING YOUR COVERAGE

If there is a change in your family, you must notify your group. The changes include:

- Birth
- Adoption
- Marriage
- Divorce
- Death of a member
- Start or end of military service

Your group must notify us directly of any changes. Your change takes effect as of the date it happens. We need to know within:

- 30 days of when a dependent is removed
- 31 days of when a dependent is added

If a dependent cannot be covered by your contract anymore, they may be able to get their own contract through COBRA or a BCBSM individual plan.

If a member on your contract dies, please notify your employer, and your rate may be adjusted as of the date of death.

Once you receive your new ID card, do not use your old one. However, keep your old card until all claims incurred under your former dental policy or contract have been processed.

TERMINATION

How to Terminate Your Coverage

Send your written request to terminate coverage to your employer or group. We must receive it from your employer or group within 30 days of the requested termination date. Your coverage will then be terminated on the requested date and all benefits under this certificate will end.

How We Terminate Your Coverage

We may terminate your coverage if:

- Your group does not qualify for coverage under this certificate.
- You no longer qualify to be a member of your group.

How We Terminate Your Coverage (continued)

We may terminate your coverage if: (continued)

- Your group does not pay its bill on time.
- You are serving a criminal sentence for defrauding BCBSM.
- We no longer offer this coverage.
- You **misuse** your coverage.

  Misuse includes illegal or improper use of your coverage such as:

  - Allowing an ineligible person to use your coverage
  - Requesting payment for services you did not receive

- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeals process.
- You are satisfying a civil judgment in a case involving BCBSM.
- You are repaying BCBSM funds you received illegally.
- You no longer qualify as a member or dependent.

Your coverage will end on the last day covered by the last payment we receive. If a child is no longer eligible for coverage because of age, coverage will end on the last day of the year in which the child turns 26.

Rescission

We will rescind your coverage if you, your group or someone seeking coverage on your behalf 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 you or a dependent obtaining or retaining this coverage with BCBSM, or the payment of claims under this or another BCBSM certificate.

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

CONTINUATION OF BENEFITS

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that applies to most employers with 20 or more employees. It allows you to continue your group coverage if you lose it due to a qualifying event such as being laid off or fired. ("Qualifying Events" are listed in Section 7.) Your employer or group must send you a COBRA notice. You have 60 days to choose to continue your coverage.

The deadline is 60 days after you lose coverage or 60 days after your employer or group sends you the notice, whichever is later. If you choose to keep the coverage, you must pay for it.

The periods of time you may keep it are:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced
- 29 months of coverage for all qualified beneficiaries if the Social Security Administration determined that one member was disabled at the time of the qualifying event or at any time during the first 60 days of the COBRA coverage.
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status or employee entitlement to Medicare.

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage ends
- The required premium is not paid on time
- The employer terminates its group health plan
- The qualified beneficiary becomes entitled to Medicare coverage
- The qualified beneficiary gets coverage under a group dental plan.

Please contact your employer or group for more details about COBRA.

Individual Coverage

If you choose not to enroll in COBRA, or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.

Section 2: What You Must Pay

You may have to pay a deductible and/or coinsurance for covered dental services. A rider or schedule of benefits that amends this certificate will explain what cost sharing you must pay.

Deductible Requirements

The deductible (if any) is the amount you must pay for covered services each benefit year before we pay for services. A rider or schedule of benefits 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 or schedule of benefits will indicate if you must pay coinsurance.

We will not apply a coinsurance to:

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

Benefit Maximums

Your coverage includes an annual benefit maximum. A rider or schedule of benefits will show the maximum amount we will pay per member for covered services provided in each benefit year. The annual maximum is separate for each person covered on your contract.

If your coverage includes orthodontic services, we will pay a separate lifetime maximum for these services. Once a member reaches this maximum, we will not pay for any more orthodontic services for that member.

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 or schedule of benefits 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
  - Diagnostic tests and laboratory examinations
  - Prophylaxes
  - Fluoride treatments
  - Sealants
  - Space maintainers
- **Radiographs (X-rays)** – as needed for routine care or to detect specific conditions.
- **Oral brush biopsy sample collection** – identifies cancerous and precancerous cells.
- **Emergency palliative treatment** – provides temporary pain relief.
- **Periodontal maintenance** – following periodontal scaling and root planing or periodontal surgery.

Class II – Basic Services

- **Restorative services** – repair decayed or damaged teeth. Restorative services are Type A services, except where noted. These services include:
  - Amalgam and resin-based composite fillings and fillings of similar materials
  - Crowns, onlays and veneers when a tooth cannot be restored with other fillings (These are Type B restorative services)
  - Substructures – cores with or without pins and posts with cores or pins
  - Recementing or repairing posts, crowns, veneers, inlays, onlays and bridges

Class II – Basic Services (continued)

- **Oral surgery services** – include the following procedures:

  - Extractions and surgical removal of teeth and roots
  - 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

- **Endodontic services** – treat teeth with diseased or damaged nerves. These services include:

  - Root canal treatment on permanent teeth and on primary teeth without permanent successors
  - Vital pulpotomies on primary teeth
  - Apical surgeries on permanent teeth
  - Hemisections on permanent teeth

- **Periodontic services** – treat diseases of the gums and the structures that support the teeth. These services include:

  - Localized delivery of antimicrobial agents
  - Periodontal scaling and root planing
  - Periodontal surgical services
  - Bone replacement grafts

- **Adjunctive general services** – are provided in connection with dental care. These services include:

  - General anesthesia or IV sedation in connection with oral or dental 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.

Class II – Basic Services (continued)

Adjunctive general services (continued)

- Office visits for observation (during regularly scheduled hours)
- Office visits after regularly scheduled hours
- Consultations by another dentist for a second opinion
- House and hospital calls
- Antibiotic injections
- Limited occlusal adjustments
- Occlusal biteguards

- **Basic prosthodontic services (Type A)** – in connection with the adjustment and repair of dentures. These services include:

  - Repairs and adjustments of partial or complete dentures
  - Relines or rebases of partial or complete dentures
  - Tissue conditioning

Class III – Major Services

- **Prosthodontic services (Type B)** – replace missing teeth. These services include:

  - Complete dentures
  - Fixed and removable partial dentures
  - Stayplates to replace recently extracted permanent anterior (front) teeth
  - Endosteal implants and implant-related services

Class IV – Orthodontic and Related Services

- **Orthodontic and related services** – detect, prevent and correct malocclusions of the teeth and any related craniofacial dysfunctions and impairments. These services include:

  - Minor treatment for tooth guidance or to control harmful habits
  - Cephalometric film and diagnostic images and photos
  - Interceptive orthodontic treatment
  - Comprehensive orthodontic treatment
  - Post-treatment stabilization

To be covered, all orthodontic services must be provided in person in the dental office by a dentist/orthodontist or an authorized member of the dentist/orthodontist's staff.

If you have orthodontic coverage, these services are covered up to the member's 19th birthday. Information about the coverage will be provided in a rider or schedule of benefits that amends this certificate.

Section 4: Exclusions & 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 or schedule of benefits 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 or appliances 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 instructions in oral hygiene, diet or plaque control programs.
- Services provided by anyone other than a dentist. However, we will cover the services of a dental hygienist when they work under the supervision of a dentist and the hygeniest is licensed to perform the services.
- Office visits for observation during regularly scheduled hours when any other treatment is provided at that same visit.
- Drugs that are not parenterally administered by a dentist in connection with covered services.
- Local anesthetic or analgesic billed as a separate service.

Exclusions (continued)

- Desensitizing medications.
- Supplies and barrier techniques used for infection control.
- Rubber dams.
- Consultations by dentists who are not treating the member, unless the treating dentist requests the consultation and it relates to a covered treatment.
- Pulp tests performed at the same visit as:
  - An oral examination or evaluation
  - A restorative, endodontic, periodontic or prosthodontic service
- Space maintainers for missing anterior (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.
- Replacing or repairing space maintainers or orthodontic appliances.
- Diagnostic photographs, skull and facial bone survey films or imaging of any type unless they are related to covered orthodontic services.
- Duplicate X-rays used for administrative or other purposes.
- Sialography.
- Biopsies performed on the same date as any other service.
- Excisional or incisional biopsies of oral lesions.
- 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).

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 adjust or restore missing tooth structure due to abrasion, attrition or erosion, except for individual consideration by report.
- Restorations to stabilize teeth, change the occlusion, correct the vertical dimension, strengthen a tooth, prevent a future problem or close a space.
- Full-mouth occlusal adjustments.
- Inlays, except under very limited circumstances with individual consideration by report.
- Prophylaxes or periodontal maintenance within 60 days of scaling and root planing or periodontal surgery.
- Prophylaxes or periodontal maintenance in conjunction with scaling and root planing, except one quadrant with individual consideration by report.
- 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.
- Bone replacement grafts performed on a different date than osseous surgery or gingival flap procedures or done in conjunction with:
  - Restorative services
  - Endodontic services
  - Oral surgery services
  - Prosthodontic services
- Onlays, crowns or veneers on primary teeth, except with individual consideration by report if there is adequate root structure and no permanent successor.
- Sargenti root canal treatment.

Exclusions (continued)

- Temporary crowns, except for fracture of anterior permanent teeth.
- Duplicate or spare complete or partial dentures.
- 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.
- Fitting a crown to a partial denture clasp.
- Charges for abutment placement or substitution for the removal of a temporary healing cap that are embedded in our payment for an endosteal implant.
- Implants other than endosteal implants.
- Services or appliances for the diagnosis or treatment of temporomandibular (jaw) joint dysfunction (TMJ).
- 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 or schedule of benefits that amends this certificate that says otherwise. We will pay for:

- Periodic oral examinations/evaluations – twice every benefit year.
- Comprehensive oral examinations/evaluations – once per dentist/dental office every 60 months.
- Prophylaxes (cleanings) – twice every benefit year.
- A set (up to four films) of bitewing X-rays – twice every benefit year.
- A full-mouth series of X-rays (including bitewing or periapical X-rays taken on the same day) or panoramic X-rays (including bitewing X-rays taken on the same day) – once every 60 months.
- Pulp tests – once every visit, regardless of the number of teeth evaluated.
- Fluoride treatments – twice every benefit year.
- Sealants – once per tooth every 36 months for first and second permanent molars for members age 19 and younger. This period begins on the date of the member's first treatment.
- Space maintainers – once per quadrant per lifetime for missing posterior primary teeth for members under age 19.
  - Recementing a space maintainer – three times per quadrant per lifetime.
- Oral brush biopsy sample collection – twice every benefit year.
- Periodontal maintenance – twice every benefit year in combination with routine cleanings.
- Amalgam and resin-based composite fillings – once per permanent (adult) tooth and surface every 24 months; once per primary (baby) tooth and surface every 12 months.
- Recementing or repairing posts, crowns, veneers, inlays, onlays or fixed partial dentures (bridges) – three times per tooth every benefit year.
- Crowns, onlays and veneers – once per permanent tooth every 60 months for members age 12 and older when the tooth cannot be restored with another filling material.
- Substructures – one type per permanent tooth every 60 months for members age 12 and older.
- Root canal treatment for a tooth involving one or more canals – once per tooth per lifetime.
  - Retreatment of a root canal 12 or more months after the initial root canal treatment – once per tooth per lifetime.

Limitations (continued)

- Hemisection – once per permanent tooth per lifetime.
- Periodontal scaling and root planing – once per quadrant every 24 months.
- Periodontal surgical services – once per quadrant every 36 months.
- Localized delivery of antimicrobial agents – one surface per tooth, three teeth per quadrant, and a maximum of 12 teeth every 12 months.
- Limited occlusal adjustments – up to five times every 60 months.
- Occlusal biteguards and relines and repairs to occlusal biteguards – once every 12 months.
- 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 60 months.
- Bridges and removable partial dentures – once every 60 months for members age 16 and older.
- Endosteal implants – once per tooth per lifetime for tooth numbers 2 through 15 and 18 through 31 for members age 16 and older.
- Crowns on implants – once per tooth every 60 months for members age 16 and older.

Section 5: How Dental Benefits Are Paid

Choosing A Dentist

Under most Blue Dental plans, you may choose any dentist. (If you are covered under a Blue Dental EPO plan, you *must* choose a Tier 1 PPO (in-network) dentist.) However, your out-of-pocket cost is less when you select a Blue Dental 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 the difference between what we paid you for covered services and the amount the dentist charges.

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 the difference (if there is any) between what we pay and what the dentist charges.

If you do not have a rider or schedule of benefits that adds a PPO network to your Blue Dental coverage, we will consider any Tier 1 PPO (in-network) dentist you see to be a Tier 2 participating non-PPO (out-of-network) dentist for payment purposes. We will reimburse that dentist directly for covered services based on our approved amount for Tier 2 participating dentists, rather than our approved amount for Tier 1 PPO dentists.

Please see the subsection titled "*Paying for Services*" in this section for more information about how we pay your dental claims.

Predetermining 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 course of 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 that 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 other 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 our required form before we pay 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 inside and outside 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 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 amount you are responsible for may also be lower.

  

  If you do not have a rider or schedule of benefits that adds a PPO network to your Blue Dental coverage, we will consider any Tier 1 PPO dentist you see to be a Tier 2 participating non-PPO (out-of-network) dentist for payment purposes. We will reimburse that dentist directly for covered services based on our approved amount for Tier 2 participating dentists, rather than our approved amount for Tier 1 PPO dentists.

- **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 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. 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 and your dentist 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 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 deny payment for any of the services that were submitted, the EOB will explain why payment was denied.

Please call Dental Customer Service if you have questions regarding payments shown on your EOB. (See Section 9: *How to Reach Us*.)

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

Your employer or group 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

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

You must complete an enrollment/change of status form and give it to your employer or group. We must receive notice from your employer or group within 30 days of when a dependent or spouse is removed from your coverage and within 31 days of when a dependent or spouse is added. Any coverage changes take effect on 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 in writing and approved by BCBSM and the Michigan Department of Insurance and Financial Services.
- We may add, limit, delete or clarify benefits in a schedule of benefits and/or rider amending this certificate. If you have a schedule of benefits or riders, keep them with this certificate.

Coordination of Benefits

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

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 the 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. (If you are covered under a Blue Dental EPO plan, you must choose a Tier 1 PPO (in-network) dentist.)

If you do not have a rider or schedule of benefits that adds a preferred provider organization (PPO) network to your Blue Dental coverage, we will consider Tier 1 PPO dentists to be Tier 2 participating dentists for payment purposes. We will reimburse them directly for covered services based on our approved amount for non-PPO (out-of-network) dentists.

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 or schedule of benefits, 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 an appliance, service, procedure, treatment or supply that has not been scientifically demonstrated to be safe and effective for treatment of the member's condition as conventional treatment. 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 that 30 days has 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

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 coverage shall continue in force.

Improper Use of Contract

If you allow an ineligible person to receive benefits (or try to receive benefits) under your contract, we may:

- Refuse to pay benefits
- Terminate or cancel your contract
- Begin legal action against you
- Refuse to cover your health care services at a later date

Individual Coverage

If you choose not to enroll in COBRA, or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.

Notification

When we need to notify you, we mail it to your employer 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

Release of Information

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

Services Before Coverage Begins or 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

We will not pay for any orthodontic treatment rendered prior to the effective date of your dental coverage.

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

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 use 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 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 provide the required notification if you want to terminate your coverage under this certificate.

Send your written request to terminate coverage to your employer or group. Your employer or group must notify BCBSM within 30 days of the requested termination date. Your coverage will then be terminated on the requested date and all benefits under this certificate 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 Provider

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 the 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.

Association Health Plan (AHP)
An AHP provides benefits to the employees of two or more unrelated employers. An AHP also may provide benefits to self-employed individuals who own, either alone or in a partnership, a trade or business. Each AHP must adhere to applicable federal and state statutes and regulations.

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

Benefit Year
A 12-month period during which your deductibles, coinsurances and annual maximums apply. Your benefit year is determined by the group offering this coverage.

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.

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 or schedule of benefits 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 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.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends, or
- You lose coverage as a dependent of the covered employee, or
- Another qualifying event occurs

If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay for you, plus a small administrative fee.

Contract
This certificate, any related riders or schedule of benefits, your signed application for coverage and your 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 schedule of benefits 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 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, 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 charge.

Department of Insurance and Financial Services (DIFS)
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.

Endosteal Implant
A device specifically designed to be placed surgically in either the upper or lower jaw where the tooth is missing. This eliminates the need to attach the false tooth to adjacent teeth in the mouth. Instead, the false tooth is attached directly to the endosteal implant structure that is embedded in bone.

Exclusions
Situations, conditions or services 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. Sometimes it is referred to as investigational or experimental services. 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

Group
An employer or association of employers that provides its members with health care coverage. An employer may provide different health care benefits to different segments or categories of its members. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

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
- Prophylaxes (teeth cleaning)
- Fluoride treatments

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.

Malocclusion
A variation from normal contact of the teeth of both jaws when closed or during movement of the lower jaw.

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".

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.

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 can you file when you disagree with our payment decision or our denial for a service that you have already received.

Predetermination
A process in which a dentist submits a treatment plan to us before the 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 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.

Qualified Beneficiary
Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualifying Event
One of the following events that allows you to enroll in different health care coverage or change your current coverage or allows a beneficiary to receive coverage under COBRA:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Start or end of military service. Members must perform military duty for more than 30 days.
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee 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.

Schedule of Benefits
A document that provides specific information about a member's deductibles, coinsurance and annual benefit maximums. It also shows which services are covered under each class of service.

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 and meets the group's eligibility requirements.

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 group's eligibility requirements.

Supervision
When a dentist oversees the care of a member, is available when necessary, but is not at chairside 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 in 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
- Rescission of coverage
  - 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 BCBSM. 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 must send 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 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 the 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 Michigan Department of Insurance and Financial Services (DIFS). You may mail your request and the required forms provided by us to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also contact DIFS with your request by phone, fax, or online:

Phone: 1-877-999-6442
Fax: 517-284-8837
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, DIFS 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 DIFS decides to accept the group's recommendation. DIFS 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.

Grievance and Appeals Process (continued)

Reviews of Dental Issues

Step 1: DIFS 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 DIFS additional information within seven days of asking for 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 DIFS.

Step 2: The review group will make a recommendation within 14 days if DIFS should uphold or reverse our decision. DIFS 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: DIFS 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 DIFS should uphold or reverse our decision. DIFS will notify you of their 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 receive it
- We failed to respond in a timely manner to a request for benefits or payment

Grievance and Appeals Process (continued)

Expedited Internal Review Process (continued)

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 DIFS.

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 DIFS.

You may request an expedited external review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive 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 General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also contact DIFS with your request by phone, fax, or online:

Phone: 1-877-999-6442
Fax: 517-284-8837
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

Grievance and Appeals Process (continued)

Expedited External Review Process (continued)

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: DIFS will decide if your request qualifies for an expedited review. If it does, DIFS will assign an independent review group to conduct the review. The group will recommend within 36 hours if DIFS should uphold or reverse our decision.

Step 4: DIFS must decide whether to accept the recommendation within 24 hours. You will be notified of DIFS's decision. This decision is the final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Pre-Service Appeals

For all members who must get approval before obtaining certain 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 physician/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 standard pre-service 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.

Pre-Service Appeals (continued)

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

For questions about your rights, this notice, or for assistance, you can call the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You can also contact the Director of the Michigan Department of Insurance and Financial Services (DIFS) 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

We Speak Your Language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 1-877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 1-877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 1-877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 1-877-469-2583, TTY: 711。

ܐܢ ܐ̱ܢܬܘܢ، ܝܢ ܚܕ ܢܫܐ ܕܩܐ ܕܡܥܕܪܘܬܘܢ، ܣܢܝܩ ܗܘܐ ܠܥܘܕܪܢܐ، ܐ̱ܢܬܘܢ ܐܝܬܠܟܘܢ ܙܕܩܐ ܕܦܠܛܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܝܠܗ ܡܓܢܐܝܬ. ܠܡܡܠܠܬܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܚܠܡܬܐ ܕܡܥܡܝܠܐ ܥܠ ܚܨܐ ܕܟܐܪܛܐ ܝܢ 1-877-469-2583 TTY:711 ܐܢ ܗ̈ܠܐ ܠܝܬܘܢ ܗܕ̈ܡܐ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 1-877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 1-877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 1-877-469-2583, TTY: 711 로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 1-877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 1-877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 1-877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 1-877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方 1-877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 1-877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 1-877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 1-877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro

Important Disclosure

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. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 1-877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide 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: 1-888-605-6461, TTY: 711, fax: 1-866-559-0578, email: CivilRights@bcbsm.com. 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 available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 1-800-368-1019, TTD: 1-800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Section 9: How to Reach Us

This section lists ways you can get information quickly.

Call Us

If you have questions about claims or coverage, you can call Dental Customer Service at **1-888-826-8152** 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.

Write Us

If you have a grievance, 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 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

INDEX

Form No. 4943

State Approved 11/2022
Effective 01/2023

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-PPO-MAC

DENTAL OPTIONS PPO
MAXIMUM ALLOWABLE CHARGE

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE
4943

This rider amends the certificate named above to:

- Add the Blue Dental PPO network to your certificate
- Change BCBSM's reimbursement for covered services provided by non-PPO (out-of-network) dentists to a Maximum Allowable Charge (MAC)
- Add definitions to your certificate

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 5: How Dental Benefits Are Paid

WHAT'S CHANGING?

This rider adds the Blue Dental PPO network to your coverage. It changes the amount BCBSM pays for covered services provided by non-PPO (out-of-network) dentists to a Maximum Allowable Charge (MAC).

Replace the language under the Choosing a Dentist subsection in your certificate with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Choosing A Dentist

This rider adds the Blue Dental PPO network to your coverage. Your out-of-pocket cost is less when you select a Blue Dental 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 the difference between what we paid you for covered services and the amount the dentist charges.**

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 the difference (if there is any) between what we pay and what the dentist charges.

Please see the subsection titled, "*Paying for Services*" in this section for more information about how we pay your dental claims.

Replace the language under the Paying for Services subsection in your certificate with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Paying for Services

We pay for covered dental services performed inside and outside the state of Michigan. Below is a description of how we pay for covered services.

This rider adds the Blue Dental PPO network to your coverage. It also makes the amounts BCBSM pays for covered services provided by non-PPO (out-of-network) dentists the same as the amounts it pays for services provided by Tier 1 PPO (in-network) dentists.

- **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 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 amount 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.

  The approved amount for non-PPO (out-of-network) dentists is higher than the MAC amount we pay them for covered services. You are responsible for paying Tier 2 participating non-PPO dentists any difference between the MAC amount and the approved amount. You are also responsible 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 (out-of-network) 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 the MAC amount, minus any cost sharing required by your plan. You are responsible for the entire amount charged by your dentist, which may be higher than the MAC amount.

Section 7: Definitions

WHAT'S CHANGING?

This rider adds definitions to your certificate.

Add the following definitions in alphabetical order:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Blue Dental PPO Network
A Preferred Provider Organization (PPO) network comprising multiple national and regional networks leased by BCBSM from selected vendors. The Blue Dental PPO network includes general dentists, endodontists, oral surgeons, orthodontists, pediatric dentists, periodontists and prosthodontists.

Maximum Allowable Charge
The maximum amount BCBSM will pay for dental services rendered by any dentist — whether that dentist is Tier 1 PPO (in-network), Tier 2 participating non-PPO (out-of-network) or nonparticipating — to a patient covered under a Blue Dental MAC plan.

GENERAL

Until further notice, all the provisions in your certificate and your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-IN-MD $50

DENTAL OPTIONS PPO (IN-NETWORK)
MEMBER DEDUCTIBLE $50

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE
4943

This rider amends the certificate named above to:

- Add a member deductible requirement for PPO (in-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a member deductible requirement for covered services provided by Tier 1 PPO (in-network) dentists.

Replace the first paragraph of the Deductible Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Deductible Requirements

The member deductible is the amount each covered member must pay for certain covered services each benefit year before we pay for services for that member.

Each member must pay the following member deductible for covered services provided by Tier 1 PPO (in-network) dentists:

- **$50 for each member**

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 323L

State Approved 11/2022
Effective 01/2023

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-IN-FD X3

DENTAL OPTIONS PPO (IN-NETWORK) FAMILY DEDUCTIBLE X3

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a family deductible requirement for PPO (in-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a family deductible requirement for covered services provided by Tier 1 PPO (in-network) dentists.

Replace the first paragraph of the Deductible Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Deductible Requirements

The family deductible is the amount your family must pay for certain covered services each benefit year before we pay for services.

- **Three or more members must meet the family deductible. If there are only two family members, each must meet the member deductible.**
- **When the deductible for any one member has been met, we will pay covered services only for that member until the full family deductible has been met.**

The family deductible amount you must pay for covered services provided by Tier 1 PPO (in-network) dentists is three times your PPO (in-network) member deductible amount.

If your *member deductible* is $25, then your family deductible is $75

Your PPO (in-network) member deductible amount can be found in Rider DO-IN-MD.

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-IN-D-C2/3

DENTAL OPTIONS PPO (IN-NETWORK) DEDUCTIBLE CLASS II AND CLASS III SERVICES

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Limit your in-network deductible requirement to covered Class II and Class III PPO (in-network) services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider limits your in-network deductible requirement to covered Class II and Class III services provided by Tier 1 PPO (in-network) dentists.

Add the following language to the Deductible Requirements subsection:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Deductible Requirements

Your PPO (in-network) deductible applies only to the following covered services:

- **Class II – Basic Services**
- **Class III – Major Services**

Your coverage includes a separate rider or riders that explain your deductible requirements.

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-NP-MD $50

DENTAL OPTIONS NON-PPO (OUT-OF-NETWORK) MEMBER DEDUCTIBLE $50

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a member deductible requirement for non-PPO (out-of-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a member deductible requirement for covered services provided by non-PPO (out-of-network) dentists.

Replace the first paragraph of the Deductible Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Deductible Requirements

The member deductible is the amount each covered member must pay for certain covered services each benefit year before we pay for services for that member.

Each member must pay the following member deductible for covered services provided by non-PPO (out-of-network) dentists:

- **$50 for each member**

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-NP-FD X3

DENTAL OPTIONS NON-PPO (OUT-OF-NETWORK) FAMILY DEDUCTIBLE X3

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a family deductible requirement for non-PPO (out-of-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a family deductible requirement for covered services provided by non-PPO (out-of-network) dentists.

Replace the first paragraph of the Deductible Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Deductible Requirements

The family deductible is the amount your family must pay for certain covered services each benefit year before we pay for services.

- **Three or more members must meet the family deductible. If there are only two family members, each must meet the member deductible.**
- **When the deductible for any one member has been met, we will pay covered services only for that member until the full family deductible has been met.**

The family deductible amount you must pay for covered services provided by non-PPO (out-of-network) dentists is three times your non-PPO (out-of-network) member deductible amount.

If your non-PPO (out-of-network) *member deductible* is $25, then your non-PPO (out-of-network) family deductible is $75

Your non-PPO (out-of-network) member deductible amount can be found in Rider DO-NP-MD.

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.

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-NP-D-C2/3

DENTAL OPTIONS NON-PPO (OUT-OF-NETWORK) DEDUCTIBLE CLASS II AND CLASS III SERVICES

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Limit your deductible requirement to covered Class II and Class III non-PPO (out-of-network) services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider limits your out-of-network deductible requirement to covered Class II and Class III services provided by non-PPO (out-of-network) dentists.

Add the following language to the Deductible Requirements subsection:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Deductible Requirements

Your non-PPO (out-of-network) deductible applies only to the following covered services:

- **Class II – Basic Services**
- **Class III – Major Services**

Your coverage includes a separate rider or riders that explain your deductible requirements.

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-IN-C2-C20%

DENTAL OPTIONS PPO (IN-NETWORK) CLASS II COINSURANCE 20%

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE
4943

This rider amends the certificate named above to:

- Add a coinsurance requirement for PPO (in-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a coinsurance requirement for covered Class II services provided by Tier 1 PPO (in-network) dentists.

Replace the first paragraph of the Coinsurance Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Coinsurance Requirements

You must pay the following coinsurance for covered Class II – Basic Services provided by Tier 1 PPO (in-network) dentists:

- **20% of the approved amount**

We will not apply a coinsurance to:

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 355L

State Approved 11/2022
Effective 01/2023

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-IN-C3-C50%

DENTAL OPTIONS PPO (IN-NETWORK) CLASS III COINSURANCE 50%

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a coinsurance requirement for PPO (in-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a coinsurance requirement for covered Class III services provided by Tier 1 PPO (in-network) dentists.

Replace the first paragraph of the Coinsurance Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Coinsurance Requirements

You must pay the following coinsurance for covered Class III – Major Services provided by Tier 1 PPO (in-network) dentists:

- **50% of the approved amount**

We will not apply a coinsurance to:

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 365L

State Approved 11/2022
Effective 01/2023

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-IN-C4-C50%

DENTAL OPTIONS PPO (IN-NETWORK) CLASS IV COINSURANCE 50%

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a coinsurance requirement for PPO (in-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a coinsurance requirement for covered Class IV services provided by Tier 1 PPO (in-network) dentists.

Replace the first paragraph of the Coinsurance Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Coinsurance Requirements

You must pay the following coinsurance for covered Class IV – Orthodontic and Related Services provided by Tier 1 PPO (in-network) dentists:

- **50% of the approved amount**

We will not apply a coinsurance to:

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-NP-C2-C40%

DENTAL OPTIONS NON-PPO (OUT-OF-NETWORK) CLASS II COINSURANCE 40%

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a coinsurance requirement for non-PPO (out-of-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a coinsurance requirement for covered Class II services provided by non-PPO (out-of-network) dentists.

Replace the first paragraph of the Coinsurance Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Coinsurance Requirements

You must pay the following coinsurance for covered Class II – Basic Services provided by non-PPO (out-of-network) dentists:

- **40% of the approved amount**

We will not apply a coinsurance to:

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-NP-C3-C50%

DENTAL OPTIONS NON-PPO (OUT-OF-NETWORK) CLASS III COINSURANCE 50%

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a coinsurance requirement for non-PPO (out-of-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a coinsurance requirement for covered Class III services provided by non-PPO (out-of-network) dentists.

Replace the first paragraph of the Coinsurance Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Coinsurance Requirements

You must pay the following coinsurance for covered Class III – Major Services provided by non-PPO (out-of-network) dentists:

- **50% of the approved amount**

We will not apply a coinsurance to:

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 387L

State Approved 10/18
Effective 01/2019

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-NP-C4-C50%

DENTAL OPTIONS NON-PPO (OUT-OF-NETWORK) CLASS IV COINSURANCE 50%

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a coinsurance requirement for non-PPO (out-of-network) covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a coinsurance requirement for covered Class IV services provided by non-PPO (out-of-network) dentists.

Replace the first paragraph of the Coinsurance Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Coinsurance Requirements

You must pay the following coinsurance for covered Class IV – Orthodontic and Related Services provided by non-PPO (out-of-network) dentists:

- **50% of the approved amount**

We will not apply a coinsurance to:

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

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-BM $1,500

DENTAL OPTIONS BENEFIT MAXIMUM $1,500

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE
4943

This rider amends the certificate named above to:

- Add an annual benefit maximum for covered services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds an annual benefit maximum for covered services.

Replace the first paragraph of the Benefit Maximums subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Benefit Maximums

Annual Benefit Maximum

Your annual benefit maximum is $1,500. This is the maximum amount we will pay per member per benefit year for covered Class I, Class II and Class III services. It applies to all covered dental services provided by Tier 1 PPO (in-network) and non-PPO (out-of-network) dentists.

You may have a set amount of the annual benefit maximum that can be used for covered services provided by non-PPO (out-of-network) dentists. See Rider DO-NP-BM for this amount.

If your coverage includes Class IV orthodontic benefits, we will pay a separate lifetime maximum for these services. Once a member reaches this maximum, we will not pay for any more orthodontic services for that member.

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-OLM $1,500

DENTAL OPTIONS ORTHODONTIC LIFETIME MAXIMUM $1,500

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a lifetime benefit maximum for covered orthodontic services

This rider is effective when you, your employer or your remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a lifetime benefit maximum for covered Class IV orthodontic services.

Replace the second paragraph of the Benefit Maximums subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Benefit Maximums

Your coverage includes an annual benefit maximum. A rider or schedule of benefits will show the maximum amount we will pay per member for covered services provided in each benefit year. The annual maximum is separate for each person covered on your contract.

Lifetime Benefit Maximum

Your lifetime benefit maximum for covered Class IV orthodontic services provided by Tier 1 PPO (in-network) and non-PPO (out-of-network) dentists is $1,500 per member. The lifetime benefit maximum is the most we will pay for each member for these services.

You may have a set amount of the lifetime benefit maximum that can be used for covered orthodontic services provided by non-PPO (out-of-network) dentists. See Rider DO-NP-OLM for this amount.

GENERAL

Until further notice, all the provisions in your certificate and in your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-IN-C1-CO%

DENTAL OPTIONS PPO (IN-NETWORK)
CLASS I COINSURANCE 0%

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE
4943

This rider amends the certificate named above to:

- Add a coinsurance requirement for covered services provided by PPO (in-network) dentists

This rider is effective when you, your employer or remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a coinsurance requirement for covered Class I services provided by PPO (in-network) dentists.

Replace the first paragraph of the Coinsurance Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Coinsurance Requirements

You must pay the following coinsurance for covered Class I – Diagnostic and Preventive Services provided by PPO (in-network) dentists:

- **No coinsurance (0% of the approved amount)**

We will not apply a coinsurance to:

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

GENERAL

Until further notice, all the provisions in your certificate and your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 768L

State Approved 01/20
Effective 03/2020

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER DO-NP-C1-CO%

DENTAL OPTIONS NON-PPO (OUT-OF-NETWORK) CLASS I COINSURANCE 0%

AMENDS

DENTAL OPTIONS GROUP BENEFIT CERTIFICATE 4943

This rider amends the certificate named above to:

- Add a coinsurance requirement for covered services provided by non-PPO (out-of-network) dentists

This rider is effective when you, your employer or remitting agent is notified.

This rider changes the coverage in your certificate. Your rider and certificate are meant to be read together. It is important to review these changes to understand how your coverage has changed.

Section 2: What You Must Pay

WHAT'S CHANGING?

This rider adds a coinsurance requirement for covered Class I services provided by non-PPO (out-of-network) dentists.

Replace the first paragraph of the Coinsurance Requirements subsection with the following:

NOTE: THE LANGUAGE IN BOLD IS NEW TO YOUR CERTIFICATE.

Coinsurance Requirements

You must pay the following coinsurance for covered Class I – Diagnostic and Preventive Services provided by non-PPO (out-of-network) dentists:

- **No coinsurance (0% of the approved amount)**

We will not apply a coinsurance to:

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

GENERAL

Until further notice, all the provisions in your certificate and your related riders are unchanged and in full force and effect, except as stated in this rider.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 769L

State Approved 01/20
Effective 03/2020