

BLUEDENTAL PPO SUMMARY OF BENEFITS



Isola USA Corp. #036431
January 1, 2023

Plan Benefit Structure				
Benefit Maximum per Member per Calendar Year All services, except Type I			\$1,500	
Annual Deductible Deductible waived for Type I services Individual Family			\$50 \$150	
Benefit Category	In-Network		Out-of-Network*	
	Plan Pays	You Pay	Plan Pays	You Pay
Type I: Preventive	100%	0%	100%	0%
	Type I services do not count toward the calendar-year maximum Deductible does not apply			
Type II: Basic	80%	20%	80%	20%
	After meeting deductible			
Type III: Major	50%	50%	50%	50%
	After meeting deductible			
Type IV: Orthodontia				
Child	50%	50%	50%	50%
Adult	50%	50%	50%	50%
Lifetime maximum	\$2,500			
Type I Covered Services				
Oral Exams	Two per year ² in any combination of periodic, limited, or comprehensive exams			
Prophylaxis	Two per year (Type II periodontal maintenance does not count toward max of two cleanings)			
Bitewing X-rays ³	Two per year			
Periapical X-rays ³	Four films per year			
Full Mouth X-rays ³	One per five-year period			
Topical Fluoride	To age 17 - two per year			
Sealants	To age 18 - once per tooth in any two-year period			
Space maintainers	To age 16			
Type II Covered Services ¹				
Fillings - Composite and Amalgam	One treatment per tooth, per surface in any two-year period (limit based on amalgam and composite fillings combined)			
Emergency Palliative Treatment	Covered for emergency treatment of dental pain			
Simple Extractions	Covered			
Oral Appliances for Treatment of Bruxism	Covered			
Oral Surgery – Surgical	Limited coverage			
Endodontics – Pulpal Therapy	One treatment per tooth in any two-year period			
Endodontics – Root Canal	One treatment per tooth in any two-year period			
Periodontics – Non-surgical	One per two-year period			
Periodontics – Surgical	One procedure per three-year period			
Type III Covered Services ¹				
Waiting Period	None			
Prosthodontics – Bridges & Dentures	60 months (5 year) replacement limit			
General Anesthesia	Limited Coverage per BCBSAZ dental coverage guidelines ⁴			
Crowns/Inlays/Onlays	60 months (5 year) replacement limit			
Implants	Covered			
Type IV Covered Services				
Orthodontics	Covered-Dependent children to age 26 and adults			
Additional Provisions				
Out of Network Reimbursement	MAC (Maximum Allowable Charge)			
Maximum Rollover Benefit	Not Covered			
Provider Network	Blue PPO			

1 If a plan determines that a less expensive alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and
b) the alternate treatment will produce a professionally satisfactory result; then the maximum the plan will allow will be the charge for the less expensive treatment.

2 All "per year" benefits mean per calendar year.

3 Any combination of x-rays billed on the same date of treatment cannot exceed the allowed amount for a full mouth x-ray benefit.

4 BCBSAZ Dental Coverage Guidelines are available upon request. Not all dentally necessary services are covered benefits.

<u>In-Network Providers</u>	<p>"In-network" dental providers have contracts with Blue Cross Blue Shield of Arizona (BCBSAZ) or with BCBSAZ's independent dental network vendor. In-network providers accept negotiated fees as payment in full for covered dental services and file a member's claims with BCBSAZ. Members usually have lower out-of-pocket costs with in-network providers.</p>																												
<u>*Out-of-Network Providers</u>	<p>"Out-of-network" providers have no contract with BCBSAZ or with BCBSAZ's independent dental network vendor. Out-of-network providers set their own rates, can collect up to full billed charges from members, and have no obligation to file members' claims.</p> <p>For out of network providers within Arizona: When MAC, it is the lesser of provider's charge or the applicable MAC schedule. When usual and customary applies, the providers billed charge will determine allowance amount.</p>																												
<u>Example</u>	<p>The following example shows how use of an in-network provider may save you money. This example assumes:</p> <ul style="list-style-type: none">• You have already met your annual deductible• You have 80% coinsurance for in-network providers• You have 80% coinsurance for out-of-network providers• Your dentist's billed charge is \$150• BCBSAZ's established in-network fee is \$100 <table><tr><th colspan="2">In-Network Provider</th><th colspan="2">Out-of-Network Provider</th></tr><tr><td>Billed Charge</td><td>\$150</td><td>Billed Charge:</td><td>\$150</td></tr><tr><td>BCBSAZ in-network fee</td><td>\$100</td><td>BCBSAZ in-network fee</td><td>\$100</td></tr><tr><td>BCBSAZ pays (80% x \$100)</td><td>\$80</td><td>BCBSAZ pays (80% x \$100)</td><td>\$80</td></tr><tr><td>You pay (20% x \$100)</td><td>\$20</td><td>You pay (20% x \$100)</td><td>\$20</td></tr><tr><td></td><td></td><td>Plus, difference of billed charge</td><td>\$50</td></tr><tr><td>Your Out-of-Pocket Cost:</td><td>\$20</td><td>Your Out-of-Pocket Cost:</td><td>\$70</td></tr></table> <p>While your actual expenses will vary, in this example, you would have saved \$50 by using an in-network provider.</p>	In-Network Provider		Out-of-Network Provider		Billed Charge	\$150	Billed Charge:	\$150	BCBSAZ in-network fee	\$100	BCBSAZ in-network fee	\$100	BCBSAZ pays (80% x \$100)	\$80	BCBSAZ pays (80% x \$100)	\$80	You pay (20% x \$100)	\$20	You pay (20% x \$100)	\$20			Plus, difference of billed charge	\$50	Your Out-of-Pocket Cost:	\$20	Your Out-of-Pocket Cost:	\$70
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<u>Optional Pre-determination</u>	<p>If your dentist has recommended services and you are concerned about coverage or costs, your dentist can ask BCBSAZ for a pre-treatment estimate, called a "pre-determination." BCBSAZ will review your dentist's proposed treatment and send your dentist information explaining what services will be covered and your estimated out-of-pocket costs for these services. A pre-determination can help you better understand what will be covered and the amount you will need to pay.</p>																												
<u>Prevention Plus</u>	<p>All diabetic and expecting mothers are eligible for coverage of one additional dental cleaning procedure or one additional periodontal maintenance procedure. For members who have enrolled in the program, extended preventive benefits will remain available for the duration of these conditions.</p>																												

BCBSAZ Standard PPO Exclusions and Limitations

Type I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling, and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients)
4. Two topical fluoride treatments per Calendar Year, to age 17
5. Bitewing x-rays, 2 per Calendar Year
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months
8. One sealant per tooth in any two year period, to age 18 (limited to permanent 1st and 2nd molars)
9. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)
10. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Type II. Basic Services:

1. Simple extraction of teeth
2. Composite and amalgam fillings per tooth per surface every 24 months (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)
3. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
4. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
5. Antibiotic injections administered by a dentist
6. Occlusal orthotic device for TMD (D7880), by report, one per five years
7. Oral surgery, including postoperative care for:
 - a. Removal of teeth, including impacted teeth
 - b. Extraction of tooth root
 - c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
 - d. Alveolectomy, alveoplasty, and frenectomy
 - e. Excision of pericoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
 - f. Tooth reimplantation and/or stabilization; tooth transplantation
 - g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
8. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
 - a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
 - b. Pulpotomy
 - c. Apicoectomy
 - d. Retrograde fillings, per root per lifetime
9. Periodontic services, limited to:
 - a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
 - b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
 - c. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years
 - d. Occlusal adjustment performed with covered surgery
 - e. Gingivectomy
 - f. Osseous surgery including flap entry and closure
 - g. One pedicle or free soft tissue graft per site per lifetime
 - h. One appliance (night guards) per 5 years within 6 months of osseous surgery
 - i. One full mouth debridement per lifetime

Type III. Major Services:

1. One study model per 36 months
2. Crown build-up for non-vital teeth
3. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
4. One repair of dentures or fixed bridgework per 24 months
5. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery, or implant placement procedures
6. Restoration services, limited to:
 - a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
 - b. Replacement of existing inlay, onlay, or crown, after 5 years of the restoration initially place or last replaced
 - c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
 - d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
7. Prosthetic services, limited to:

- a. Initial placement of removable dentures or fixed bridges
- b. Replacement of removable dentures or fixed bridges that cannot be repaired after 5 years from the date of last placement
- c. Addition of teeth to existing partial denture
- d. One relining or rebasing of existing removable dentures per 24 months
- e. Implants and related services

Type IV. Orthodontia services and tooth extractions. (Please refer to pages 1 and 2 of the benefit summary for Orthodontia coverage)

Diagnostic services, active and retention treatment to include removable, fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:

- 1. Services which are covered under Medicare, worker's compensation, or employer's liability laws.
- 2. Services which are not necessary for the patient's dental health.
- 3. Reconstructive, plastic, cosmetic, elective, or aesthetic dentistry.
- 4. Oral surgery requiring the setting of fractures and dislocations.
- 5. Services with respect to malignancies, cysts, or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
- 6. Dispensing of drugs.
- 7. Hospitalization for any dental procedure.
- 8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
- 9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
- 10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony (except for D7880).
- 11. Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth.
- 12. Services not listed as covered.
- 13. Replacement of lost, stolen, or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
- 14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
- 15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
- 16. Treatment of cleft palate, malignancies, or neoplasms.