



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

LAKE SUPERIOR STATE UNIVERSITY

007004176 - 0000

Dental Coverage

Effective Date: On or after January 2025

Benefits-at-a-glance

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

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

Dentist information

With Blue Dental PPO, you can choose any licensed dentist anywhere. However, you'll get the best coverage and save the most money when you choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the country through the Blue Dental PPO network. Tier 1 PPO dentists agree to accept our PPO approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 1 PPO dentist near you, log into your member account at **bcbsm.com** or call **1-888-826-8152**.

If you go to a non-PPO dentist, you can still save money by choosing a Tier 2 participating non-PPO (out-of-network) dentist. Tier 2 dentists participate with us on a "per claim" basis through our Blue Par Select (BPS) arrangement. They accept our BPS approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 2 participating non-PPO dentist near you, log into your member account at **bcbsm.com**. You should ask your dentist if they participate with BCBSM before every treatment.

Note: If you go to a nonparticipating dentist, you are responsible for any difference between our approved amount and the dentist's charge.

Member	Eligibility Criteria
Dependents	- Subscriber's legal spouse - Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn age 26, provided all eligibility requirements are met.

Member's responsibility (deductible, coinsurance and dollar maximums)	
Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services)	30%
Class I services	
Class II services	30%
Class III services	30%

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Benefits	Coverage
Class IV services	50%
Dollar maximums	\$1,000 per member
- Annual maximum for Class I, II and III services - Lifetime maximum for Class IV services	\$1,500 per member

Class I services

Benefits	Coverage
Oral exams	70% of approved amount Note: Twice per calendar year
A set (up to 4 films) of bitewing x-rays	70% of approved amount Note: Twice per calendar year
Panoramic or full-mouth x-rays	70% of approved amount Note: Once every 60 months
Prophylaxis (cleaning)	70% of approved amount Note: Twice per calendar year
Sealants - for members age 19 and younger	70% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars. This period begins on the date of the member's first treatment.
Emergency palliative treatment	70% of approved amount
Fluoride treatments	70% of approved amount Note: Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	70% of approved amount Note: Once per quadrant per lifetime
Periodontic maintenance	70% of approved amount

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	70% of approved amount Note: Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	70% of approved amount Note: Replacement fillings covered after 12 months or more after initial filling
Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older	70% of approved amount Note: Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	70% of approved amount Note: Three times per tooth per calendar year after six months from original restoration
Oral surgery	70% of approved amount
Root canal treatment	70% of approved amount Note: Once per tooth per lifetime; retreatment of previous root canal therapy once per tooth per lifetime.
Scaling and root planing	70% of approved amount Note: Once every 24 months per quadrant
Limited occlusal adjustments	70% of approved amount Note: Limited occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	70% of approved amount Note: Once every 12 months
General anesthesia or IV sedation	70% of approved amount Note: When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	70% of approved amount Note: Six months or more after denture is delivered

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Benefits	Coverage
Relining or rebasing of a partial or complete denture	70% of approved amount Note: Once per arch in any 36 consecutive months
Tissue conditioning	70% of approved amount Note: Once per arch in any 36 consecutive months

Class III services	
Benefits	Coverage
Removable dentures (complete and partial)	70% of approved amount Note: Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	70% of approved amount Note: Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	70% of approved amount Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services	
Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

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

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Vision Coverage

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Essential Vision benefits are provided by Heritage Vision Plans. Heritage Vision Plans is an independent company providing vision benefit services for Blues members. To find a Heritage Vision Plans network provider, call **1-800-252-2053** or visit Heritage Vision Plans online at heritagevisionplans.com.

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

Benefits	Network doctor	Non-network provider
Eye exam	\$5 copay	\$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay
Medically necessary contact lenses	\$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay
Note: No copay is required for prescribed contact lenses that are not medically necessary.		

Eye exam		
Benefits	Network doctor	Non-network provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	\$5 copay	Reimbursement up to \$35 less \$5 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

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Lenses and frames		
Benefits	Network doctor	Non-network provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. Note: Preferred pricing discounts on noncovered lens options and upgrades, and on an additional prescription eyeglass or sunglass (second pair) purchase when obtained from a network provider.	\$7.50 copay (one copay applies to both lenses and frames) One pair of lenses, with or without frames, in any period of 12 consecutive months	Reimbursement up to approved amount based on lens type less \$7.50 copay (member responsible for any difference)
Standard frames	\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less \$7.50 copay (one copay applies to both frames and lenses) One frame in any period of 12 consecutive months	Reimbursement up to \$65 less \$7.50 copay (member responsible for any difference)

Contact lenses		
Benefits	Network doctor	Non-network provider
Medically necessary contact lenses (requires prior authorization approval from Heritage and must meet criteria of medically necessary)	\$7.50 copay Contact lenses up to the allowance in any period of 12 consecutive months	Reimbursement up to approved amount less \$7.50 copay (member responsible for any difference)
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance) Contact lenses up to the allowance in any period of 12 consecutive months when services are rendered by a Heritage network provider.	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)

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