Montana University System Student Insurance Plan

Effective August 1, 2024

Dental

MEMBER GUIDE

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

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STUDENTALMG2024

FOR CUSTOMER SERVICE:
CALL 1-866-739-4090
or
FAX 1-888-788-3269

FOR CLAIMS, SEND TO:
Blue Cross and Blue Shield of Montana
PO Box 660247
Dallas, TX 75266-0247

FOR APPEALS, SEND TO:
Blue Cross and Blue Shield of Montana
PO Box 660247
Dallas, TX 75266-0247

Blue Cross and Blue Shield of Montana
3645 Alice Street
Helena, MT 59604-4309

Access our Website at: www.bcbsmt.com

Certain terms in this Member Guide are defined in the Definitions section of this Member Guide. Defined terms are capitalized.

NO COVERAGE UNTIL DUES PAID

This Member Guide is being provided to you because Montana University System Student Insurance Plan has agreed to purchase coverage from Blue Cross and Blue Shield of Montana. The Member's coverage will not be effective, and you will not be entitled to Benefits, until and unless Montana University System Student Insurance Plan pays the required Dues.

MEMBER GUIDE

This Member Guide is a summary of the Benefits available under the Montana University System Student Insurance Plan. Nothing in this Member Guide will alter any of the terms, conditions, limitations, or Exclusions of the Montana University System Student Insurance Plan. If questions should arise, the provisions of the Montana University System Student Insurance Plan will prevail. Please refer to the Montana University System Student Insurance Plan on file if you have any questions which aren't answered in the Member Guide or call Blue Cross and Blue Shield of Montana.

PRIVACY OF INSURANCE AND HEALTH CARE INFORMATION

It is the policy of Blue Cross and Blue Shield of Montana to protect the privacy of Members through appropriate use and handling of private information. Further, appropriate handling and security of private information may be mandated by state and/or federal law.

The Montana University System Student Insurance Plan and Member may receive a copy of Blue Cross and Blue Shield of Montana's "Notice of Privacy Practices," or other information about privacy practices, by calling the telephone number or writing to the address shown on the inside cover of this Member Guide.

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SCHEDULE OF BENEFITS

Dental

Student Health Plan Name:	Montana University System Student Insurance Plan
Student Health Plan Number:	X58188
Effective Date:	August 1, 2024
Benefit Period:	August 1, 2024 through July 31, 2025

Additional days of coverage may be available for newly enrolled students, depending on the coverage period registration dates at each specific campus.

The Benefits are subject to the Benefit Period unless otherwise specified.

Benefits are only provided for Members under 19 years of age.

DENTAL SERVICES	The Plan will pay Participating Providers	The Plan will pay Non-Participating Providers*
Diagnostic Evaluations (Deductible waived)	80%	80%
Preventive Services (Deductible waived)	80%	80%
Diagnostic Radiographs (Deductible waived)	80%	80%
Miscellaneous Preventive Services (Deductible waived)	80%	80%
Basic Restorative Services	50%	50%
Non-Surgical Extractions	50%	50%
Adjunctive Services	50%	50%
Non-Surgical Periodontal Services	50%	50%
Endodontic Services	50%	50%
Oral Surgery Services	50%	50%
Surgical Periodontal Services	50%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Miscellaneous Restorative and Prosthodontic Services	50%	50%
Orthodontic Services – Deductible does not apply		
Pediatric Orthodontic Services: Coverage limited to Members under age 19 with an orthodontic condition meeting Medical Necessity criteria (e.g., severe, dysfunctional malocclusion) established by The Plan	50%	50%
Deductible (In and Out-of-Network accumulate together)		
Individual	$75	

*The Member may be responsible for any amount by which the actual charges of an Out-of-Network Provider exceed the Allowable Fee.

PROVIDERS OF CARE FOR MEMBERS

Covered Providers may be Participating Providers or nonparticipating providers.

Participating Providers

Participating Providers include those providers who or which have a contract with Blue Cross and Blue Shield of Montana and are listed in the current provider directory. The providers include Participating Blue Cross and Blue Shield of Montana Professional Providers and Participating Blue Cross and Blue Shield of Montana Facility Providers.

Nonparticipating Providers

A nonparticipating professional or facility provider does not have a contract with Blue Cross and Blue Shield of Montana.

The Member may be responsible for a greater portion of the cost for any covered services received from the nonparticipating provider than if the Member had received the same covered services from a Participating Provider.

How Providers are Paid by The Plan and Member Responsibility

Payment by The Plan for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield of Montana provider network.

A **Participating Provider** agrees to accept payment of the Allowable Fee from Blue Cross and Blue Shield of Montana for covered services, together with any Deductible and Coinsurance from the Member, as payment in full. Generally, The Plan will pay the Allowable Fee for a covered service directly to a Participating Provider. In any event, The Plan may, in its discretion, make payment to the Member, the provider, the Member and provider jointly, or any person, firm, or corporation who paid for the services on the Member's behalf.

Nonparticipating providers do not have to accept Blue Cross and Blue Shield of Montana payment as payment in full. Blue Cross and Blue Shield of Montana reimburses a nonparticipating provider for covered services according to the Allowable Fee. The nonparticipating provider can bill the Member for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus Deductible and Coinsurance. The Member will be responsible for the balance of the nonparticipating provider's charges after payment by Blue Cross and Blue Shield of Montana and payment of any Deductibles and Coinsurance.

The Plan will not pay for any services, supplies, or medications which are not covered services, or for which a Benefit maximum has been met, regardless of whether provided by a Participating Provider or a nonparticipating provider. The Member will be responsible for such services, supplies, or medications.

Pretreatment Estimate of Benefits and Treatment Plan

If the Member's Dentist recommends a Course of Treatment that will cost more than $300, the Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs and models and an estimate of the charges prior to beginning the Course of Treatment. The Plan will review the report and materials, taking into consideration any alternative adequate Course of Treatment, and will notify the Member and the Dentist of the estimated Benefits which will be provided under this Member Guide. This is not a guarantee of payment, but an estimate of the Benefits available for the proposed services to be rendered. The Plan's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and Member Guide requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, the Member is responsible for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by The Plan.

COMPLAINTS AND GRIEVANCES

Complaints and Grievances

The Plan has established a Complaint and Grievance process. A Complaint involves a communication from the Member expressing dissatisfaction about The Plan's services or lack of action or disagreement with The Plan's response. A Grievance will typically involve a Complaint about a provider or a provider's office and may include Complaints about a provider's lack of availability or quality of care or services received from a provider's staff.

Most problems can be handled by calling Customer Service at the number appearing on the inside cover of this Member Guide. The Member may also file a written Complaint or Grievance with The Plan. The fax number, email address, and mailing address of The Plan appears on the inside cover of this Member Guide. Written Complaints or Grievances will be acknowledged within 10 days of receipt. The Member will be notified of The Plan's response within 60 days from receipt of the Member's written Complaint or Grievance.

APPEALS

Claim Determination

The Member has the right to seek and obtain a full and fair review by The Plan of any determination of a claim or any other determination.

If a Claim Is Denied or Not Paid in Full

If the claim is denied in whole or in part, a written notice from Blue Cross and Blue Shield of Montana will be provided with the following information, if applicable:

1. The reasons for the determination;
2. A reference to the Benefit Plan provisions on which the determination is based;
3. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
4. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care provider, claim amount (if applicable), and a statement describing denial codes with their meanings. Upon request, treatment codes with their meanings and the standards used are also available;
5. An explanation of The Plan's internal review/Appeals and external review processes (and how to initiate a review/Appeal or external review) and a statement of right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/Appeal;
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's dental circumstances, if the denial was based on Dental Necessity, experimental treatment or similar Exclusion, or a statement that such explanation will be provided free of charge upon request; and
9. Contact information for consumer Appeal assistance program.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are two types of claims as defined below.

1. Pre-Service Claim is any request for Benefits or a determination with respect to which the terms of the Benefit Plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining dental care.
2. Post-Service Claim is notification in a form acceptable to The Plan that a service has been rendered or furnished. This notification must include full details of the service received, including the name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the

date of service, the claim charge, and any other information which The Plan may request in connection with services rendered.

Pre-Service Claims

Type of Notice	Timing
The Plan must notify of the claim determination (whether adverse or not):	
If The Plan received all information necessary to complete the review, within:	2 working days of receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and 3 calendar days of the request if the claim is denied.

Post-Service Claims

Type of Notice or Extension	Timing
If the claim is incomplete, The Plan must notify the Member within:	30 days
If the Member is notified that the claim is incomplete, the Member must then provide completed claim information to The Plan within:	45 days after receiving notice
The Plan must notify the Member of any adverse claim determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	45 days
*This period may be extended one time by The Plan for up to 15 days, provided that The Plan both (1) determines that such an extension is necessary due to matters beyond the control of The Plan and (2) written notification is sent prior to the expiration of the initial 30-day period if the circumstances requiring the extension of time and the date by which The Plan expects to render a decision.	

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An “Adverse Benefit Determination” means a denial, reduction, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, or failure to provide in response to a claim, or Pre-Service Claim, or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental/investigational or not Dentally Necessary or appropriate. If an ongoing Course of Treatment had been approved by The Plan and The Plan reduces such treatment (other than by amendment) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

How to Appeal an Adverse Benefit Determination

The Member has the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for prior authorization, or any other determination made by The Plan. An Appeal of an Adverse Benefit Determination may be filed by the Member, or a person authorized to act on the Member’s behalf. In some circumstances, a dental care provider may Appeal on his/her own behalf. The Member may orally request an Appeal if the requested dental service has been denied on the basis that it is not Dentally Necessary or it is experimental or investigational. If the Member believes The Plan incorrectly denied all or part of the claim, the Member may have the claim reviewed. The Plan will review its decision in accordance with the following procedure:

1. Within 180 days after the notice of an Adverse Benefit Determination, the Member may write to The Plan to request a claim review. The Plan will need to know the reasons why the Member does not agree with the Adverse Benefit Determination. Send the request to:

Blue Cross and Blue Shield of Montana
PO Box 660247
Dallas, TX 75266-0247

2. The Plan will honor telephone requests for information; however, such inquiries will not constitute a request for review.
3. In support of the claim review, the Member has the option of presenting evidence and written testimony to The Plan. The Member and/or an authorized representative may ask to review the file and any relevant documents and may submit written issues, comments and additional dental information within 180 days after the Member receives notice of an Adverse Benefit Determination or at any time during the claim review process.

The Plan will provide the Member and authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of the claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to the Member or an authorized representative sufficiently in advance of the date a final decision on Appeal is made in order to give the Member a chance to respond. If the initial Benefit determination regarding the claim is based in whole or in part on a dental judgment, the Appeal determination will be made by a Dentist associated or contracted with The Plan and/or by external advisors, but who were not involved in making the initial denial of the claim.

1. If the Member has any questions about the claims procedures or the review procedure, write to Blue Cross and Blue Shield of Montana or call toll-free Customer Service Helpline number shown on the inside cover of the Member Guide or on the Member's Identification Card.

Timing of Appeal Determinations

The Plan will render a determination of the pre-service Appeal as soon as practical, but in no event more than 30 days after the Appeal has been received by The Plan.

The Plan will render a determination of the post-service Appeal as soon as practical, but in no event more than 60 days after the Appeal has been received by The Plan.

If You Need Assistance

For questions about the claims procedures or the review procedure, write Blue Cross and Blue Shield of Montana at the address below or call at 1-866-739-4090. Customer Service is accessible from 8:00 A.M. to 6:00 P.M., Monday through Friday.

Blue Cross and Blue Shield of Montana
PO Box 660247
Dallas, TX 75266-0247

For additional assistance with an Appeal, a Member may also contact the Commissioner of Securities and Insurance at: Montana Commissioner of Securities and Insurance, 840 Helena Ave., Helena, MT 59601 or call 1-800-332-6148 or 406-444-2040.

If assistance is needed with the internal claims and Appeals or the external review processes that are described below, call the number on the back of the Member's Identification Card for contact information. In addition, for questions about the Appeal rights or for assistance, the Member can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Plan will notify the party filing the Appeal, the Member, and, if a clinical Appeal, any dental care provider who recommended the services involved in the Appeal, by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the Benefit Plan provisions on which the determination is based;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, treatment codes with their meanings are also available;
4. An explanation of The Plan's external review processes (and how to initiate an external review) and a statement of the Member's right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external Appeal;

5. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
6. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
7. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
8. Contact information for applicable office of consumer program assistance.

If The Plan denies the Appeal, in whole or in part, or a timely decision is not made, the Member has the right to request an external review of the claim by an independent third party, who will review the denial and issue a final decision. The external review rights are described in the How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO) section below.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)

An "Adverse Determination" means a determination by The Plan or its designated utilization review organization that a dental care service that is a covered service has been reviewed and, based upon the information provided, is determined to be experimental/investigational, or does not meet The Plan's requirements for Dental Necessity, or appropriateness and the requested service or payment for the service is therefore denied or reduced.

A "Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by The Plan at the completion of The Plan's internal review/Appeal process.

This procedure (not part of the Complaint process) pertains only to Appeals of Adverse Determinations

Any party whose Appeal of an Adverse Determination is denied by The Plan may seek review of the decision by an IRO. At the time the Appeal is denied, The Plan will provide the Member or a designated representative or Provider of record, information on how to Appeal the denial, including the approved form, which the Member or a designated representative, or Provider of record must complete.

1. The Plan will submit dental records, names of Providers and any documentation pertinent to the decision of the IRO.
2. The Plan will comply with the decision by the IRO.
3. The Plan will pay for the independent review.

Upon request and free of charge, the Member or Member's designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or Appeal, including:

1. Information relied upon to make the decision;
2. Information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
3. Descriptions of the administrative process and safeguards used to make the decision;
4. Records of any independent reviews conducted by The Plan;
5. Dental judgments, including whether a particular service is experimental/investigational or not Dentally Necessary or appropriate; and
6. Expert advice and consultation obtained by The Plan in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The Appeal process does not prohibit the Member from pursuing other appropriate remedies, including injunctive relief; a declaratory judgment or other relief available under law. If the dental insurance plan is governed by the Employee Retirement Income Security Act (ERISA), the Member may have the right to bring civil action under 502(a) of ERISA.

ELIGIBILITY AND ENROLLMENT

Who is Eligible

1. All students under age 19 are eligible if they are a fee-paying student taking at least 6 credit hours or more at a participating campus. A student enrolled for less than 6 credit hours is not eligible to enroll in the Student Health Plan.

2. Participation Requirements

a. All students enrolled for 6 credit hours, or more, are required to carry health insurance coverage. Students can enroll for coverage when they register on-line for classes.

The Student Health Plan fee will be assessed each Fall and Spring coverage period at registration.

b. Enrollment in the Student Health Plan is required for all International Students (residing within the United States), at all campuses regardless of the number of credit hours, unless proof of other coverage in the United States is submitted to the campus.

The Student Health Plan fee will be assessed each Fall and Spring coverage period at registration.

c. Waiver of coverage must be made within the first 15 class days of the coverage period. Fall and Spring students with proof of other coverage will be allowed to waive coverage.

No eligibility rules or variations in premium will be imposed based on health status, medical or dental condition, claims experience, receipt of healthcare, medical or dental history, genetic information, evidence of insurability, disability, or any other health status related factor. Applicants will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Variation in the administration, processes or Benefits of this policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Enrollment/Waiver Process

The Effective Date of coverage (for those who apply within the periods of eligibility) will be the date assigned by the Montana University System Student Insurance Plan.

A specific period of time is allowed at the beginning of each coverage period for enrolling in The Plan or waiving coverage. For the Fall and Spring coverage periods, the enrollment/waiver period begins on the first day of scheduled classes each coverage period and ends 15 class days later.

Effective Date of Coverage

1. For the Member:

a. The Effective Date of coverage for a Member shall be the first day of the applicable coverage period.

b. If a Member becomes eligible after the beginning of the applicable coverage period, the Member's Effective Date will be the first day of the applicable coverage period after the required premium is paid.

2. For Newborn Children:

For a newborn born to a Member, the moment of birth. Coverage will continue for 31 days only. Coverage for the newborn will be provided only if the Member remains covered on the health plan during the 31- day period. If the Member does not remain covered for 31 days, the newborn will only be covered for the amount of time (during the 31 days) that the Member is covered.

3. For Adoption or Placement for Adoption:

In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption. In the event the placement is disrupted prior to legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted. Coverage will continue for 31 days only. Coverage for the child will be provided only if the Member remains covered on the health plan during the 31-day period. If the Member does not remain covered for 31 days, the child will only be covered for the amount of time (during the 31 days) that the Member is covered.

Special Enrollment for Loss of Eligibility

Eligible students will not be allowed to enroll in The Plan after the applicable enrollment/waiver period unless proof is furnished that the student became ineligible for coverage under another group insurance plan during the 31 days immediately preceding the date of the request for late enrollment. The coverage will be for the entire coverage period.

Conditions for Special Enrollment for Loss of Eligibility

1. When the student declined enrollment for the Student Insurance Plan, the student stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment; and
   - **a.** The student had COBRA continuation coverage and the COBRA continuation coverage has expired; or
   - **b.** The student had other coverage that was not under a COBRA continuation provision and the other coverage has been terminated because of:
     1. A loss of eligibility for the coverage. Loss of eligibility for coverage includes a loss coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the forgoing. However, loss of eligibility does not include a loss of coverage due to failure of the individual or the Member to pay premiums on a timely basis or termination of coverage for cause; or
     2. A situation in which The Plan no longer offers any Benefits to the class of similarly situated individuals that includes the individual.
   - **c.** The student loses eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the student becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.
2. The student must request enrollment not later than 31 days after the exhaustion of the COBRA continuation coverage or termination of the other coverage because of loss of eligibility or termination of employer contributions.
3. The student must request enrollment not later than 60 days after the date of termination of coverage under either the Children's Health Insurance Program or the Medicaid Program.
4. The student must request enrollment not later than 60 days after the date the student is determined to be eligible for premium assistance under the Children's Health Insurance Program or the Medicaid Program.
5. Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of The Plan and the provisions of this Member Guide.

Effective Date of Enrollment

Enrollment due to loss of eligibility will be the first day of the applicable coverage period after the required premium is paid.

When Benefits Begin

The Member is entitled to the Benefits of this Member Guide beginning on the Member's Effective Date.

Change of Status

Change of Status forms should be completed and returned to The Plan for:

1. Name changes; or
2. Address changes.

TERMINATION OF COVERAGE

Termination When No Longer Eligible for Coverage

When No Longer Eligible for Coverage

Member coverage will terminate on the earlier of:

1. The last day of the Month for which payment has been made;
2. The date the university is no longer participating in the Student Health Plan; or
3. The date of entry into military service, except for temporary duty of 30 days or less.

In the event the Member withdraws from the university within the 100 percent refund period, the following action may take place:

If an unexpected illness or accident forces the Member to drop classes, and the Member's intent was to finish the course of study during the coverage period, the Member may be covered for the remainder of the coverage period. (In this case, the Director of the Student Health Center would make the decision on whether a medical release is in order.) Members who intend to pursue this option should contact the Health Center within the 100 percent refund period.

DENTAL SERVICES

The Benefits of this section are subject to all the terms and conditions of this Member Guide. Benefits are available only for services and supplies that are determined by The Plan to be Dentally Necessary, unless otherwise specified. All Dental Services listed in this section are subject to the Exclusions and Limitations section of this Member Guide, which lists services, supplies, situations or related expenses that are not covered.

The Schedule of Benefits indicates what the Deductible, Coinsurance and Benefit Period Maximum will be for a Dental Service.

Dental Benefits include coverage for the following Dental Services as long as these services are rendered by a Dentist or a Physician. When the term "Dentist" is used in this Member Guide, it will mean Dentist or Physician**.**

Diagnostic Evaluations

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

Periodic oral evaluation - Limited to 1 every 6 Months
Limited oral evaluation - problem focused
Comprehensive oral evaluation - Limited to 1 every 6 Months
Detailed and extensive oral evaluation - problem focused - by report
Comprehensive periodontal evaluation
Consultation (diagnostic service provided by Dentist or physician other than practitioner providing treatment)

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

Preventive Services

Preventive services are performed to prevent dental disease. Dental Services include:

Prophylaxis - Adult - Limited to 1 every 6 Months
Prophylaxis - Child - Limited to 1 every 6 Months
Topical fluoride varnish - Less than age 19 – Limited to 2 every 12 Months
Topical application of fluoride (excluding prophylaxis) - Less than age 19 – Limited to 2 every 12 Months

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Periodontal maintenance combined with prophylaxes treatments (see "Non-Surgical Periodontic Services") are limited to four in a 12-Month period following completion of active periodontal therapy.

Diagnostic Radiographs

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

Intraoral - complete series (including bitewings) – Limited to 1 every 60 Months
Intraoral - periapical first film
Intraoral - periapical - each additional film
Intraoral - occlusal film
Bitewing - single film – Limited to: Adult - 1 set every calendar year / Children - 1 set every 6 Months
Bitewings - two films – Limited to: Adult - 1 set every calendar year / Children - 1 set every 6 Months

Bitewings - four films – Limited to: Adult - 1 set every calendar year / Children - 1 set every 6 Months
Vertical bitewings - 7 to 8 films – Limited to: Adult - 1 set every calendar year / Children - 1 set every 6 Months
Panoramic film – Limited to 1 film every 60 Months
Cephalometric x-ray
Oral / Facial Photographic Images
Interpretation of Diagnostic Image

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

Miscellaneous Preventive Services

Miscellaneous preventive services are other services performed to prevent dental disease and include:

Sealant - per tooth - unrestored permanent molars - Less than age 19 - 1 sealant per tooth every 36 Months
Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 Months.
Space maintainer - fixed - unilateral - Limited to children under age 19
Space maintainer - fixed - bilateral - Limited to children under age 19
Space maintainer - removable - unilateral - Limited to children under age 19
Space maintainer - removable - bilateral - Limited to children under age 19
Re-cementation of space maintainer - Limited to children under age 19

Benefits are not available for nutritional, tobacco and oral hygiene counseling.

Basic Restorative Services

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Dental Services include:

Amalgam - one surface, primary or permanent
Amalgam - two surfaces, primary or permanent
Amalgam - three surfaces, primary or permanent
Amalgam - four or more surfaces, primary or permanent
Resin-based composite - one surface (anterior)
Resin-based composite - two surfaces (anterior)
Resin-based composite - three surfaces (anterior)
Resin-based composite - four or more surfaces or involving incisal angle (anterior)

Benefits will not be provided for restorations placed within 12 Months of the initial placement by the same Dentist.

Non-Surgical Extractions

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Non-Surgical Periodontal Services

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

Periodontal scaling and root planing - four or more teeth per quadrant - Limited to 1 every 24 Months
Periodontal scaling and root planing - one to three teeth, per quadrant - Limited to 1 every 24 Months
Scaling gingival inflammation - Limited to 1 every 6 Months combined with prophylaxis and periodontal maintenance
Full mouth debridement to enable comprehensive evaluation and diagnosis - Limited to 1 per lifetime
Periodontal maintenance - 4 every 12 Months combined with adult prophylaxis after the completion of active periodontal therapy
Collect - Apply Autologous Product - Limited to 1 every 36 Months

Adjunctive Services

Adjunctive general services include:

Adjunctive general services
Palliative treatment of dental pain - minor procedure
Deep sedation/general anesthesia - first 30 minutes
Deep sedation/general anesthesia - each additional 15 minutes
Intravenous conscious sedation/analgesia - first 30 minutes
Intravenous conscious sedation/analgesia - each additional 15 minutes
Therapeutic drug injection - by report

Endodontic Services

Endodontics is the treatment of dental disease of the tooth pulp and includes:

Endodontic services
Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.
Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.
Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 - Limited to once per tooth per lifetime.
Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) - Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 - Limited to once per tooth per lifetime.
Anterior root canal (excluding final restoration)
Bicuspid root canal (excluding final restoration)
Molar root canal (excluding final restoration)
Retreatment of previous root canal therapy - anterior
Retreatment of previous root canal therapy - bicuspid
Retreatment of previous root canal therapy - molar
Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
Apicoectomy/periradicular surgery - anterior
Apicoectomy/periradicular surgery - bicuspid (first root)
Apicoectomy/periradicular surgery - molar (first root)
Apicoectomy/periradicular surgery - (each additional root)
Root amputation - per root
Hemisection (including any root removal) - not including root canal therapy

Oral Surgery Services

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

Oral surgery services
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
Removal of impacted tooth - soft tissue
Removal of impacted tooth - partially bony
Removal of impacted tooth - completely bony
Removal of impacted tooth - completely bony with unusual surgical complications

Surgical removal of residual tooth roots - (cutting procedure)
Coronectomy - intentional partial tooth removal
Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
Surgical access of an unerupted tooth
Alveoloplasty in conjunction with extractions - per quadrant
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
Alveoloplasty not in conjunction with extractions - per quadrant
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
Removal of exostosis
Incision and drainage of abscess - intraoral soft tissue
Suture of recent small wounds up to 5 cm
Bone replacement graft for ridge preservation - per site
Excision of pericoronal gingiva

Surgical Periodontal Services

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

Gingivectomy or gingivoplasty - four or more teeth - Limited to 1 every 36 Months
Gingivectomy or gingivoplasty - one to three teeth - Limited to 1 every 36 Months
Gingivectomy or gingivoplasty - with restorative procedures, per tooth – Limited to 1 every 36 Months
Gingival flap procedure, four or more teeth - Limited to 1 every 36 Months
Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant - Limited to 1 every 36 Months
Clinical crown lengthening hard tissue
Osseous surgery (including flap entry and closure) four or more contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 Months
Osseous surgery (including flap entry and closure) one to three contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 Months
Pedicle soft tissue graft procedure
Subepithelial connective tissue graft procedures (including donor site surgery)
Soft tissue allograft - Limited to 1 every 36 Months
Free soft tissue graft - 1st tooth
Free soft tissue graft - additional teeth
Treatment of complications (post-surgical) unusual circumstances - by report

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

Major Restorative Services

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

Detailed and extensive oral evaluation – problem focused - by report
Inlay - metallic - one surface - An alternate Benefit will be provided
Inlay - metallic - two surfaces - An alternate Benefit will be provided
Inlay - metallic - three surfaces - An alternate Benefit will be provided
Onlay - metallic - two surfaces - Limited to 1 per tooth every 60 Months
Onlay - metallic - three surfaces - Limited to 1 per tooth every 60 Months
Onlay - metallic - four or more surfaces - Limited to 1 per tooth every 60 Months
Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 Months
Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 Months
Crown - porcelain fused to predominately base metal - Limited to 1 per tooth every 60 Months
Crown - porcelain fused to noble metal - Limited to 1 per tooth every 60 Months
Crown - 3/4 cast high noble metal - Limited to 1 per tooth every 60 Months
Crown - 3/4 cast predominately base metal - Limited to 1 per tooth every 60 Months
Crown - 3/4 porcelain/ceramic - Limited to 1 per tooth every 60 Months
Crown - full cast high noble metal - Limited to 1 per tooth every 60 Months

Crown - full cast predominately base metal - Limited to 1 per tooth every 60 Months
Crown - full cast noble metal - Limited to 1 per tooth every 60 Months
Crown - titanium - Limited to 1 per tooth every 60 Months
Post and core - Limited to 1 per tooth every 60 Months
Protective Restoration
Inlay Repair
Onlay Repair
Veneer Repair
Resin infiltration/smooth surface - Limited to 1 every 36 Months

Benefits will not be provided for the replacement of a lost, missing or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

Benefits will not be provided for services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures may include, but are not limited to, equilibration dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

Benefits will not be provided for services to restore occlusion on incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 Months whether placement was provided under this Member Guide or under any prior dental coverage, even if the original crown was stainless steel.

Prosthodontic Services

Prosthodontics involve procedures necessary for providing artificial replacements for missing natural teeth and includes:

Adjust complete denture - maxillary
Adjust complete denture - mandibular
Adjust partial denture - maxillary
Adjust partial denture - mandibular
Repair broken complete denture base
Replace missing or broken teeth - complete denture (each tooth)
Repair resin denture base
Repair cast framework
Repair or replace broken clasp
Replace broken teeth - per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Rebase complete maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Rebase maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Rebase mandibular partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline complete maxillary denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline complete mandibular denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline mandibular partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-Month period 6 Months after initial installation
Complete denture - maxillary - Limited to 1 every 60 Months
Complete denture - mandibular - Limited to 1 every 60 Months
Immediate denture - maxillary - Limited to 1 every 60 Months
Immediate denture - mandibular - Limited to 1 every 60 Months
Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth) - Limited to 1 every 60 Months

Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months

Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests, and teeth) - Limited to 1 every 60 Months

Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests, and teeth) - Limited to 1 every 60 Months

Removable unilateral partial denture - one piece cast metal (including clasps and teeth) - Limited to 1 every 60 Months

An implant is a covered procedure only if determined to be a Dental Necessity. Claim review is conducted by The Plan who reviews the clinical documentation submitted by the treating Dentist. If The Plan determines an arch can be restored with a standard prosthesis or restoration, no Benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase - placing of the implant crown, bridge denture or partial denture) may be subject to the alternate Benefit provision of The Plan (see “Alternate Care”).

Endosteal Implant - 1 every 60 Months

Surgical Placement if Interim Body - 1 every 60 Months

Eposteal Implant - 1 every 60 Months

Transosteal Implant, including hardware - 1 every 60 Months

Implant supported complete denture

Implant supported partial denture

Connecting Bar - implant or abutment supported - 1 every 60 Months

Prefabricated Abutment - 1 every 60 Months

Custom Abutment - 1 every 60 Months

Abutment supported porcelain ceramic crown - 1 every 60 Months

Abutment supported porcelain fused to high noble metal - 1 every 60 Months

Abutment supported porcelain fused to predominately base metal crowns

Abutment supported porcelain fused to noble metal crown - 1 every 60 Months

Abutment supported cast high noble metal crown - 1 every 60 Months

Abutment supported cast predominately base metal crown - 1 every 60 Months

Abutment supported cast noble metal crown - 1 every 60 Months

Implant supported porcelain/ceramic crown - 1 every 60 Months

Implant supported porcelain fused to high metal crown - 1 every 60 Months

Implant supported metal crown - 1 every 60 Months

Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 Months

Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 Months

Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 Months

Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 Months

Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 Months

Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 Months

Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 Months

Implant supported retainer for ceramic fixed partial denture - 1 every 60 Months

Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 Months

Implant supported retainer for cast metal fixed partial denture - 1 every 60 Months

Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 Months

Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 Months

Implant Maintenance Procedures - 1 every 60 Months

Scaling and debridement implant - 1 every 60 Months

Repair Implant Prosthesis - 1 every 60 Months

Replacement of Semi-Precision or Precision Attachment - 1 every 60 Months

Repair Implant Abutment - 1 every 60 Months

Implant Removal - 1 every 60 Months

Debridement periimplant defect, covered if implants are covered - Limited to 1 every 60 Months

Debridement and osseous periimplant defect, covered if implants are covered - Limited to 1 every 60 Months

Bone graft implant periimplant defect, covered if implants are covered

Bone graft implant replacement, covered if implants are covered

Implant Index - 1 every 60 Months
Pontic - cast high noble metal - Limited to 1 every 60 Months
Pontic - cast predominately base metal - Limited to 1 every 60 Months
Pontic - cast noble metal - Limited to 1 every 60 Months
Pontic - titanium - Limited to 1 every 60 Months
Pontic - porcelain fused to high noble metal - Limited to 1 every 60 Months
Pontic - porcelain fused to predominately base metal - Limited to 1 every 60 Months
Pontic - porcelain fused to noble metal - Limited to 1 every 60 Months
Pontic - porcelain/ceramic - Limited to 1 every 60 Months
Inlay/onlay - porcelain/ceramic - Limited to 1 every 60 Months
Inlay - metallic - two surfaces - Limited to 1 every 60 Months
Inlay - metallic - three or more surfaces - Limited to 1 every 60 Months
Onlay - metallic - three surfaces – Limited to 1 every 60 Months
Onlay - metallic - four or more surfaces – Limited to 1 every 60 Months
Retainer - cast metal for resin bonded fixed prosthesis – Limited to 1 every 60 Months
Retainer - porcelain/ceramic for resin bonded fixed prosthesis – Limited to 1 every 60 Months
Resin retainer - for resin bonded fixed prosthesis – Limited to 1 every 60 Months
Crown - porcelain/ceramic – Limited to 1 every 60 Months
Crown - porcelain fused to high noble metal – Limited to 1 every 60 Months
Crown - porcelain fused to predominately base metal – Limited to 1 every 60 Months
Crown - porcelain fused to noble metal – Limited to 1 every 60 Months
Crown - 3/4 cast high noble metal – Limited to 1 every 60 Months
Crown - 3/4 cast predominately base metal – Limited to 1 every 60 Months
Crown - 3/4 cast noble metal – Limited to 1 every 60 Months
Crown - 3/4 porcelain/ceramic – Limited to 1 every 60 Months
Crown - full cast high noble metal – Limited to 1 every 60 Months
Crown - full cast predominately base metal – Limited to 1 every 60 Months
Crown - full cast noble metal – Limited to 1 every 60 Months
Occlusal guard, by report – Limited to 1 every 12 Months for patients 13 and older
Repair/reline occlusal guard – Limited to 1 every 24 Months for patients 13 and older
Occlusal guard adjustment – Limited to 1 every 24 Months for patients 13 and older

Note: Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

Note: Implant retained crowns, bridges, and dentures are subject to the alternate Benefit provision of The Plan (see “Alternate Care”).

- Endosteal, eposteal, and transosteal implants – Limited to 1 every 60 Months only if determined to be a Dental Necessity.

Benefits will not be provided for the following Prosthodontic Services:

- Treatment to replace teeth which were missing prior to the Effective Date
- Congenitally missing teeth
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework

Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

Diagnostic Models
Re-cement inlay
Re-cement or re-bond indirectly fabricated or prefabricated post and core
Re-cement crown
Prefabricated porcelain crown - primary - Limited to 1 every 60 Months
Prefabricated stainless steel crown - primary tooth - Under age 15 - Limited to 1 per tooth in 60 Months
Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth every 60 Months
Core buildup, including any pins - Limited to 1 per tooth every 60 Months
Pin retention - per tooth, in addition to restoration

Prefabricated post and core, in addition to crown - Limited to 1 per tooth every 60 Months
Crown repair - by report
Re-cement fixed partial denture
Fixed partial denture repair - by report

Medically Necessary Orthodontic Services

Benefits for Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth. Coverage for orthodontic services is shown on the Schedule of Benefits. Covered services include:

Limited orthodontic treatment of the primary dentition
Limited orthodontic treatment of the transitional dentition
Limited orthodontic treatment of the adolescent dentition
Limited orthodontic treatment of the adult dentition
Interceptive orthodontic treatment of the primary dentition
Interceptive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the adolescent dentition
Comprehensive orthodontic treatment of the adult dentition
Removable appliance therapy
Fixed appliance therapy
Pre-orthodontic treatment visit
Periodic orthodontic treatment visit (as part of Member Guide)
Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Note: Benefits for codes D0330, D0340, D0350, and D0470 will be applied to the lifetime orthodontia maximum when performed as part of orthodontia treatment.

Special Provisions Regarding Orthodontic Services:

Pediatric Orthodontic Services – Coverage is limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria established by The Plan (e.g., severe, dysfunctional malocclusion).

Benefits for Medically Necessary orthodontic services are limited to Members who meet the Policy criteria related to a medical condition including but are not limited to:

- Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
- Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services; and
- Skeletal anomaly involving maxillary and/or mandibular structures;

Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

Orthodontic treatment is started on the date the bands or appliances are inserted. Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the Benefit Period maximum for orthodontic services.

If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.

Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Member is not covered.

Benefits are not available for replacement or repair of an orthodontic appliance.

For services in progress on the Effective Date, Benefits will be reduced based on the Benefits paid prior to this coverage beginning.

Telehealth

Dentally Necessary Telehealth services are covered when provided by a Covered Provider.

EXCLUSIONS AND LIMITATIONS

All Benefits provided under this Member Guide are subject to the Exclusions and Limitations in this section and as stated under the Benefit section.

Important Information About the Member's Dental Benefits

1. Dental Procedures Which Are Not Medically Necessary

Please note that in order to provide dental care Benefits at a reasonable cost, this Member Guide provides Benefits only for those covered Dental Services and eligible dental treatment that are determined by The Plan to be Medically Necessary.

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

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

2. Care By More Than One Dentist

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

3. Non-Compliance with Prescribed Care

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

The Plan will not pay for:

1. Services and treatment not prescribed by or under the direct supervision of a Dentist, except in those states where dental hygienists are permitted to practice without supervision by a Dentist. In these states, The Plan will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;

1. Services and treatment which are experimental or investigational;

2. Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This Exclusion applies whether or not you claim the benefits or compensation;

3. Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;

4. Services and treatment performed prior to the Member's Effective Date of coverage;

5. Services and treatment incurred after the termination date of the Member's coverage unless otherwise indicated;

6. Services and treatment which are not Dentally Necessary, or which do not meet generally accepted standards of dental practice;

7. Services and treatment resulting from the Member's failure to comply with professionally prescribed treatment;

8. Telephone consultations;

9. Any charges for failure to keep a scheduled appointment;

10. Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

11. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);

12. Services or treatment provided as a result of intentionally self-inflicted injury or illness;

13. Any loss for which a contributing cause was the commission of a felony or serious illegal act, or an attempt to commit a felony or a serious illegal act, for which the Member has been found guilty in a court of competent jurisdiction or to which the Member has plead guilty or no contest. This Exclusion does not apply to the extent the Member suffers a loss as a victim of domestic violence;

14. Office infection control charges;

15. Charges for copies of the Member's records, charts or x-rays, or any costs associated with forwarding/mailing copies of the Member's records, charts or x-rays;

16. State or territorial taxes on Dental Services performed;

17. Those submitted by a Dentist, which is for the same services performed on the same date for the same Member by another Dentist;

18. Those provided free of charge by any governmental unit, except where this Exclusion is prohibited by law;

19. Those for which the Member would have no obligation to pay in the absence of this or any similar coverage;

20. Those which are for specialized procedures and techniques;

21. Those performed by a Dentist who is compensated by a facility for similar covered services performed for Members;

22. Duplicate, provisional and temporary devices, appliances, and services;

23. Plaque control programs, oral hygiene instruction, and dietary instructions;

24. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;

25. Gold foil restorations;

26. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;

27. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;

28. Hospital costs or any additional fees that the Dentist or hospital charges for treatment at the hospital (inpatient or outpatient);

29. Charges by the provider for completing dental forms;

30. Adjustment of a denture or bridgework which is made within 6 Months after installation by the same Dentist who installed it;

31. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;

32. Cone Beam Imaging and Cone Beam MRI procedures;

33. Sealants for teeth other than permanent molars;

34. Precision attachments, personalization, precious metal bases and other specialized techniques;

35. Replacement of dentures that have been lost, stolen or misplaced;

36. Orthodontic care for dependent children age 19 and over;

37. Repair of damaged orthodontic appliances;

38. Replacement of lost or missing appliances;

39. Fabrication of athletic mouth guard;

40. Internal and external bleaching;
41. Nitrous oxide;
42. Oral sedation;
43. Topical medicament center;
44. Orthodontic care for a Member or spouse covered under the Standard Plan Option;
45. Bone grafts when done in connection with extractions, apicoectomies or non-covered/non-eligible implants;
46. When two or more services are submitted, and the services are considered part of the same service to one another The Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by The Plan;
47. When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), The Plan will pay for the service that represents the final treatment as determined by The Plan;
48. Amounts which are in excess of the Allowable Fee, as determined by The Plan.

CLAIMS

How to Obtain Payment for Benefits

1. If a Member obtains Benefits from a participating provider, the participating provider will submit claims to The Plan for the Member. If a Member obtains Benefits from a nonparticipating provider, the Member may be required to submit all claims to The Plan. All claims for services must be submitted no later than 12 Months after the date on which the services were received after the end of the Benefit Period in which Dental Services were provided. All claims must provide enough information about the services for The Plan to determine whether or not they are a Benefit. Submission of such information is required before payment will be made. In certain instances, The Plan may require that additional documents or information including, but not limited to, accident reports, medical records, and information about other insurance coverage, claims, payments and settlements, be submitted within the timeframe requested for the additional documentation before payment will be made.

   NOTE: The Member must submit all claims for Dental Services provided outside of the state of Montana.

2. Claims must be submitted to the address listed on the inside cover of this Member Guide.

GENERAL PROVISIONS

Modification of Member Guide

The Plan may make administrative changes or changes in Dues, terms or Benefits in the Montana University System Student Insurance Plan by giving written notice to the Montana University System Student Insurance Plan at least 60 days in advance of the Effective Date of the changes. Dues may not be increased more than once during a 12-Month period, except as allowed by Montana law.

No change in the Member Guide will be valid unless in writing and signed by the President of Blue Cross and Blue Shield of Montana. No other agent or representative or employee of The Plan may change any part of this Member Guide.

Clerical Errors

No clerical error on the part of The Plan shall operate to defeat any of the rights, privileges, or Benefits of any Member covered under this Member Guide. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of the Member Guide in strict accordance with its terms.

Notices Under Contract

Any notice required by the Contract may be given by United States mail, postage paid. Notice to the Member will be mailed to the address appearing on the records of The Plan. Notice to The Plan must be sent to Blue Cross and Blue Shield of Montana at the address listed on the inside cover of this Member Guide. Any time periods included in a notice shall be measured from the date the notice was mailed.

A Member or family member may reasonably request, in writing, that any communication of the Member's health information be sent to an alternate address or by alternative means should disclosure of any of the Member's health information endanger the Member.

Contract Not Transferable by the Member

No person, other than the Member listed on the subscriber application for membership and accepted by The Plan, is entitled to Benefits under the Contract. The Contract is not transferable to any other person.

Rescission of Member Guide

This Member Guide is subject to rescission if the Member commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Member’s health, claims history, or current receipt of health care services. The Plan will provide at least 30 days advance written notice to the subscriber before coverage may be rescinded.

Validity of Contract

If any part, term, or provision of the Contract is held by the courts to be illegal or in conflict with or not in compliance with any applicable law of the state of Montana or the United States, the Contract shall not be rendered invalid but shall be construed and applied in accordance with such provisions as would have applied had the Contract been in conformance with applicable law and the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Contract did not contain the particular part, term, or provision held to be invalid.

Waiver

The waiver by The Plan of any breach of any provision of this Member Guide will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure of The Plan to exercise any right hereunder will not operate as a waiver of such right. All rights and remedies provided herein are cumulative.

Payment by the Plan

Payment under the Contract is not assignable by the Member to any third party. Payment made by The Plan shall satisfy any further obligation of The Plan.

Conformity with Montana Statutes

The provisions of this Member Guide conform to the minimum requirements of Montana law and have control over any conflicting statutes of any state in which the insured resides or may receive health services on or after the Effective Date of this Member Guide.

Forms for Proof of Loss

The Plan shall furnish, upon request of a Member, forms for filing proof of loss. If forms are not furnished within 15 days after the Member provided notice of sickness or injury to The Plan, the Member is considered to have complied with the requirements of the Contract as to proof of loss upon submitting, with the time established in the Contract for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proofs of Loss

Written proof of loss must be furnished to The Plan at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which The Plan is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to

furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

Legal Actions

No action at law or inequity shall be brought to recover on this Member Guide prior to the expiration of 60 days after written Proof of Loss has been furnished in accordance with the requirements of this Member Guide. No such action shall be brought after the expiration of three years after the written Proof of Loss is required to be furnished.

Time of Payment of Claims

The Plan will pay or deny a claim within 30 days after receipt of a Proof of Loss unless The Plan makes a reasonable request for additional information or documents in order to evaluate the claim. If The Plan makes a reasonable request for additional information or documents, The Plan shall pay or deny the claim within 60 days of receiving the Proof of Loss unless The Plan has notified the Member, the Member's authorized representative, or the claimant of the reasons for failure to pay the claim in full or unless The Plan has a reasonable belief that insurance fraud has been committed and The Plan has reported the possible insurance fraud to the Commissioner of Insurance. This section does not eliminate a Plan's right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

If The Plan fails to comply with this section and The Plan is liable for payment of the claim, The Plan shall pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after The Plan's receipt of the Proof of Loss or 60 days after receipt of the Proof of Loss if The Plan made a reasonable request for information or documents. Interest payments must be made to the person who receives the claims payment. Interest is payable under this subsection only if the amount of interest due on a claim exceeds $5.

Physical Examinations

Blue Cross and Blue Shield of Montana, at its own expense, shall have the right and opportunity to examine the person of a Member when and as often as it may reasonably require during the pending of a claim and also the right and opportunity to make an autopsy in case of death when it is not prohibited by law.

Members Rights

Members have only those rights as specifically provided in this Member Guide. In addition, when requested by the insured or the insured's agent, Montana law requires The Plan to provide a summary of a Member's coverage for a specific health care service or Course of Treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or Hospital exceeds $500.

Alternate Benefits

In all cases in which there is more than one service or Course of Treatment to treat the Member's dental condition, the Benefit will be based on the less costly covered services or Course of Treatment.

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

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

If the Member and the Member's Dentist decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for Dental Services rather than standard procedures, the Benefits provided will be limited to the Benefit for the least costly Course of Treatment or procedures for Dental Services, as determined by The Plan.

Benefit Maximums

Once The Plan pays the maximum amount for a specific Benefit, no further payment will be made for that specific condition under any other provisions of this Member Guide.

Subrogation

1. To the extent that Benefits have been provided or paid under this Member Guide, The Plan may be entitled to subrogation against a judgment or recovery received by a Member from a third party found liable for a wrongful act or omission that caused the Injury requiring payment for Benefits.
2. The Member will take no action through settlement or otherwise which prejudices the rights and interest of The Plan under this Member Guide.
3. If the Member intends to institute an action for damages against a third party, the Member will give The Plan reasonable notice of intention to institute the action. Reasonable notice will include information reasonably calculated to inform The Plan of facts giving rise to the third-party action.
4. The Member may request that The Plan pay a proportional share of the reasonable costs of the third-party action, including attorney fees. If The Plan elects not to participate in the cost of the action, The Plan waives 50 percent of its subrogation interest.
5. The right of subrogation may not be enforced until the Member has been completely compensated for the injuries.

Statements are Representations

All statements and descriptions in any application shall be considered representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the Member Guide unless:

1. Fraudulent;
2. Material either to the acceptance of the risk or to the hazard assumed by The Plan; or
3. The Plan in good faith would not have issued the Member Guide, would not have issued the Member Guide in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to The Plan as required either by the application for the Member Guide or otherwise. No statement made for the purpose of effecting coverage shall avoid such coverage or reduce Benefits unless contained in a written instrument signed by the Member, a copy of which has been furnished to such Member.

Right to Audit

The Plan reserves the right to audit the eligibility records to determine whether all students are eligible. The Plan further reserves the right to correspond directly with employees to obtain affidavits certifying such eligibility.

Independent Relationship

Participating providers furnishing care to a Member do so as independent contractors with The Plan; however, the choice of a provider is solely the Member's. Under the laws of Montana, The Plan cannot be licensed to practice medicine or surgery and The Plan does not assume to do so. The relationship between a provider and a patient is personal, private, and confidential. The Plan is not responsible for the negligence, wrongful acts, or omissions of any providers, or provider's employees providing services, or Member receiving services. The Plan is not liable for services or facilities which are not available to a Member for any reason.

Blue Cross and Blue Shield of Montana as an Independent Plan

The Montana University System Student Insurance Plan, on behalf of itself and its students, hereby expressly acknowledges its understanding that this Member Guide constitutes a contract solely between the Montana University System Student Insurance Plan and The Plan, that The Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting The Plan use the Blue Cross and Blue Shield Service Mark in the state of Montana, and that The Plan is not contracting as the agent of the Association. The Montana University System Student Insurance Plan further acknowledges and agrees that it has not entered into the Contract based upon representations by any person other than The Plan and that no person, entity, or organization other than The Plan shall be held accountable or liable to the Montana University System Student Insurance Plan for any of The Plan's obligations to the Montana University System Student Insurance Plan created under the Contract. This paragraph shall not create any additional obligations whatsoever on the part of The Plan other than those obligations created under other provisions of the Contract.

DEFINITIONS

This section defines certain words used throughout this Member Guide. These words are capitalized whenever they are used as defined.

ALLOWABLE FEE

1. The amount determined by The Plan as the maximum amount eligible for payment of Benefits. A participating Dentist agrees to accept payment of the Allowable Fee from The Plan for Dental Services, together with any Deductible, Coinsurance and/or Copayment from the Member, as payment in full. Nonparticipating Dentists do not have to accept The Plan's payment as payment in full and can bill the Member for the difference between payment by The Plan and provider charges plus Deductible, Coinsurance and/or Copayment. The Member will be responsible for the balance of the nonparticipating Dentist's charges after payment by The Plan and payment of any Deductible, Coinsurance and/or Copayment.
2. An amount which is the lesser of:
   - The amount billed by the nonparticipating Dentist; or
   - The maximum allowance, as determined by The Plan based on the fees which Dentists in the same relative geographic area usually charge patients for the same Dental Service
3. The amount determined by The Plan which participating Providers have agreed to accept as payment in full for a particular Dental Service. These amounts may be amended from time to time by The Plan.

APPEAL

Request for review of a denied or partially denied claim and/or services.

BENEFIT

Services, supplies and medications that are provided to a Member and covered under this Member Guide as a covered Dental Service.

BENEFIT PERIOD

For the Member Guide - Is the period of time shown in the Schedule of Benefits.

For the Member - Is the same as for the Member Guide except if the Member's Effective Date is after the Effective Date of the Member Guide, the Benefit Period begins on the Member's Effective Date and ends on the same date the Member Guide Benefit Period ends. Thus, the Member's Benefit Period may be less than 12 Months.

COINSURANCE

The percentage of the Allowable Fee payable by the Member for covered Dental Services. The applicable Coinsurance for In-Network covered Dental Services and Out-of-Network covered Dental Services is stated in the Schedule of Benefits.

COMPLAINT

Any communication from the Member or on the Member's behalf which expresses:

1. Dissatisfaction;
2. Disagreement;
3. Lack of action; or
4. Threats.

CONTRACT

The Contract, the application and any amendments, endorsements, riders, or modifications to the Contract made to it by The Plan.

COURSE OF TREATMENT

Any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERED PROVIDER

A participating or nonparticipating provider which has been recognized by Blue Cross and Blue Shield of Montana as a provider of services for Benefits described in this Member Guide. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, The Plan looks to the nature of the services rendered, the extent of licensure and The Plan's recognition of the provider.

DEDUCTIBLE

The dollar amount each Member must pay for Dental Services incurred during the Benefit Period before The Plan will make payment for any Dental Services to which the Deductible applies. Only the Allowable Fee for Dental Services is applied to the Deductible. Thus, Member responsibility for Coinsurance, noncovered services, or amounts billed by nonparticipating providers, does not apply to the Deductible.

DENTAL PROVIDER

A Dental Provider may be participating or nonparticipating. A participating Dental Provider is a provider who has a contract with Blue Cross and Blue Shield of Montana. These providers agree to accept payment directly from Blue Cross and Blue Shield of Montana for covered dental Benefits. This payment, together with the Member's Deductible and Coinsurance described in the Schedule of Benefits, is accepted as payment in full. The Member may obtain a list of participating Dental Providers from Blue Cross and Blue Shield of Montana upon request.

If a Member receives services from a nonparticipating Dental Provider, the Member is responsible for the balance of the nonparticipating provider's bill after payment by Blue Cross and Blue Shield of Montana.

DENTAL SERVICES

Dental Services for which allowances are provided in this Member Guide.

DENTIST

A person licensed to practice dentistry in the state where the service is provided.

DENTURIST

A person licensed as a Denturist in the state where the service is provided.

EFFECTIVE DATE

For a Member - the Effective Date of a Member's coverage means the date the Member:

1. Has met the requirements of The Plan stated in this Member Guide; and
2. Is shown on the records of The Plan to be eligible to receive Benefits.

For the Member Guide - the Effective Date of the Member Guide is the date shown on the face of this Member Guide.

For any endorsement, rider, or amendment - the Effective Date is the date shown on the Member Guide unless otherwise shown on the endorsement, rider and amendment.

EXCLUSION

A provision which states that The Plan has no obligation under this Member Guide to make payment.

GRIEVANCE

A Complaint about the quality of care, or services rendered by a provider or provider officer.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

A specific procedure or supply provided to the Member that is reasonably required, in the judgment of The Plan, for the treatment or management of the Member's specific dental symptom, injury, or condition and is the most efficient and economical procedure that can safely be provided to the Member. The fact that a Dentist or other provider may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants, retained by The Plan. These consultants review the claim and diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

MEMBER

The student who has applied for, been accepted as a Member, and maintains membership in The Plan under the terms of this Member Guide.

MEMBER GUIDE

The summary of Benefits issued to a Member that describes the Benefits available under the Montana University System Student Insurance Plan.

MONTH

For the purposes of this Member Guide, a Month has 30 days even if the actual calendar Month is longer or shorter.

PLAN - THE PLAN

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

TELEHEALTH

The use of audio, video, or another telecommunications technology or media, including audio-only communication that is:

1. Used by a health care provider or health care facility to deliver health care services; and
2. Delivered over a secure connection that complies with state and federal laws.

Telehealth does not include delivery of Dental Services by means of facsimile machine or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

BlueCross BlueShield of Montana

Health care coverage is important for everyone.
If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance. Office of Civil Rights Coordinator 300 E. Randolph St., 35th Floor Chicago, IL 60601 Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960
You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at: U.S. Dept. of Health & Human Services 200 Independence Avenue SW Room 509F, HHH Building 1019 Washington, DC 20201 Phone: 800-368-1019 TTY/TDD: 800-537-7697 Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.

Blue Cross and Blue Shield of Montana
3645 Alice Street

Helena, MT 59604-4309

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