

2018

DENTAL INSURANCE PLANS FOR YOU & YOUR FAMILY



Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

affordable

DENTAL AND VISION PLANS



PEDIATRIC

For children under the age of 19, this plan meets the Affordable Care Act (ACA) guidelines for preventive and restorative dental care.



SILVER

For children under age 19, this plan covers the same benefits as the pediatric plan, however, member cost share (copayments or coinsurance) may differ. For adults, it covers preventive services, as well as some minor and major restorative services.



GOLD

For children under age 19, this plan covers the same benefits as the pediatric plan, however, member cost share (copayments or coinsurance) may differ. For adults, it covers the preventive and minor restorative services covered by the Silver plan, and adds major restorative services. It also includes the Rollover Benefit.



GOLD PLUS VISION

This plan is available for children and adults. It includes the same dental benefits as the Gold plan in addition to vision coverage.



DENTAL PLANS

	PEDIATRIC	SILVER		GOLD	
	Child Only	Child(ren)	Adult	Child(ren)	Adult
Plan Year Maximum	Unlimited	Unlimited	\$1,000	Unlimited	\$1,000
Annual Limit on Cost Sharing	\$350	\$350 for One Child; \$700 for Two or More Children	Unlimited	\$350 for One Child; \$700 for Two or More Children	Unlimited
Rollover Benefit	None	None	None	None	Yes
Dental Xtra	Yes	Yes	Yes	Yes	Yes
Calendar-Year Benefits	Member Pays				
Deductible	\$20	\$50		\$20	
Diagnostic and Preventive Coverage Exams, Prophylaxis (Teeth Cleaning), X-rays (Pediatric Plan Also Covers Fluoride Treatment and Sealants)	0%	10%		0%	
Minor Restorative Coverage Fillings, Endodontics (Root Canals), Oral Surgery, Extractions, Periodontics (Treatment for Gum Disease) (Pediatric Plan Also Covers Anesthesia)	20%	30%	25%	20%	
Major Restorative Coverage All Ages — Crowns, Partials and Dentures, Surgical Periodontics 19 and over — Bridges, Inlays and Onlays, Implants Orthodontics not covered	50%	50%	50% **	50%	
Implants	Not Covered	Not Covered		Not Covered	Covered
Orthodontics	Not Covered	Not Covered		Not Covered	
Waiting Periods*	None	None	6 Months Minor Restorative	None	6 Months Minor / 6 Months Major Restorative
Monthly Rates (per person)					
Rates Per Person (Children Ages 0-20; Adult Ages 21 and up)	\$30.22	\$23.94	\$22.57	\$30.22	\$34.78

Note: Information in grid represents in-network benefits.

To determine a monthly "family rate," add individual rates together according to ages. If you have more than 3 children, you will only be charged for the first 3 children on the policy.

Example: Silver Plan for a family of 4 (2 adults, 2 children)

\$22.57 x 2 = \$45.14

\$23.94 x 2 = \$47.88

Total Premium \$93.02 per month

** Re-cementations, repairs and adjustments only.

* The six-month waiting period for minor restorative services (Silver or Gold) and the six-month waiting period for major restorative services (Gold) will be waived if you meet the following criteria:

- Your application is received within **30** days of the termination date of your previous coverage; and
- No later than **60** days from the effective date of your new policy with Arkansas Blue Cross and Blue Shield, you provide us with:
 - A copy of your previous dental policy Certificate of Coverage, which reflects the policy's effective and termination dates; and
 - A copy of your previous policy's benefit schedule, which reflects at least six months of coverage for minor and/or major restorative services.

Note: In order to waive the major restorative waiting period, previous coverage must include comprehensive major restorative services such as crowns and bridges.



GOLD PLUS VISION

In addition to all of the Dental Gold benefits, with Dental Gold Plus Vision, you have:

- Coverage for eye examinations and eyeglasses or contact lenses
- The ability to maximize your benefits by using an eye doctor or eye-care center in the network*
- The freedom to choose any eye doctor*

PLAN COVERAGE THROUGH A VSP NETWORK DOCTOR

Benefit	Description (Frequency: Every 12 months)
Annual Eye Exam	Eye exam covered-in-full, after \$10 copay
Lenses	<ul style="list-style-type: none"> Glass or plastic, single vision, lined bifocal, lined trifocal or lenticular prescription lenses are covered-in-full, after \$25 copay Oversize lenses, scratch-resistant coating covered-in-full Polycarbonate lenses are covered-in-full for children (ages 18 and under) Most popular lens enhancements are also covered, subject to an additional copay^{1,2} 20% savings on additional glasses or sunglasses, within 12 months of vision exam^{2,3}
Frames	<ul style="list-style-type: none"> Frames are covered-in-full⁴ up to \$125 allowance² 20% off any amount exceeding allowance² Frames are covered-in-full⁴ up to \$70 allowance at Walmart²
Contact Lenses	<ul style="list-style-type: none"> Elective contact lens materials (instead of glasses) are covered-in-full up to \$100 allowance 15% savings on contact lens exam services; copay not to exceed \$60² Find additional savings on contact lenses by clicking on "special offers" at vsp.com

VALUE ADDED BENEFIT

VSP Laser VisionCare SM Program	<ul style="list-style-type: none"> VSP-contracted laser centers provide discounts for laser surgery, including Photo Refractive Keratectomy (PRK), Custom PRK, Lasik, Custom Lasik and Intralase⁵ VSP has negotiated special pricing with participating centers, which can add up to hundreds of dollars in savings for VSP members. Contact the centers near you to learn more about their pricing.⁶ Find a VSP-contracted Laser VisionCare provider at vsp.com
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DENTAL GOLD PLUS VISION MONTHLY RATES (per person)

Individual (age 0-20)	\$36.62	Individual (age 21 and up)	\$41.18
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See Important Information (Page 8) on vision out-of-network reimbursement.

*It will cost more to visit an out-of-network eye doctor. To see which eye doctors are in the network, visit **vsp.com**.

¹Most popular lens enhancements include progressives, anti-reflective, photochromics, polycarbonate, plastic dyes, and UV protection. All other lens enhancements also available at 20% savings. ²Based on applicable laws; benefits may vary by location. ³Discounts valid through any VSP network doctor within 12 months of the last covered eye exam. ⁴Less any applicable copay. ⁵Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. ⁶The VSP Laser VisionCare Program[®] is a discount plan only. Discounts only apply to services received from a VSP participating laser center. No monetary benefits are payable to members under this program.

QUESTIONS?

Call your agent today.

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Rollover Benefit

The Gold plan's annual maximum rollover benefit allows individual adults to "roll over" up to \$350 of unused benefits to the next year.

With the annual maximum rollover benefit feature, you may roll over \$350 to the next calendar year, as long as:

- You submit at least one claim during the year; **and**
- Your total claims do not exceed \$500 for that calendar year.

With Dental Gold, the rollover is available to each adult member on your policy and it can accumulate from one calendar year to the next, up to a maximum of \$1,000. This means you can potentially have a \$2,000 annual maximum per adult member, which can provide even more protection for those unexpected dental bills.

DENTAL XTRA

Dental Xtra is a program for Arkansas Blue Cross dental insurance members who are pregnant, have diabetes, coronary artery disease suffered a stroke, have been diagnosed with oral cancer or Sjögren's syndrome. It provides qualifying members with additional dental benefits, which are paid 100% when using a participating dentist, won't count toward the maximum dollar amount your dental plan will cover for the calendar year, requires no co-payment, coinsurance or deductible.

ENROLL AT ZERO COST:

- 1 Visit arkansasdentalblue.com
- 2 Click "Enroll online" on the left-hand side
- 3 Fill out the "Enroll in Dental Xtra" online form
- 4 Wait for your enrollment form to be evaluated
- 5 Receive a welcome letter about one month after enrollment

Dental Xtra	Prophylaxis (cleanings) or periodontal maintenance* visit every 3 months	Periodontal Scaling* , or scaling in the presence of gingival inflammation every 24 months	Pre-diagnostic oral cancer screening** every 6 months	Fluoride Treatment** Every 3 Months
Diabetes	✓	✓		
Coronary Artery Disease	✓	✓		
Stroke (as of January 1, 2018)	✓	✓		
Pregnancy	✓	✓		
Oral Cancer	✓		✓	✓
Sjögren's syndrome (as of January 1, 2018)	✓		✓	✓

*Periodontal maintenance and scaling available with plans that offer periodontal benefits.

**This benefit is available for members who have previously been diagnosed with oral cancer or for members diagnosed with Sjögren's syndrome.

MOST POPULAR LENS ENHANCEMENTS FOR THE DENTAL GOLD PLUS VISION PLAN

- Most lens enhancements are covered after a copay, saving members an average of 20 – 25%

Lens Enhancement	Single Vision ¹	Multifocal ¹
Solid Tints and Dyes (Pink I and II)	\$0	\$0
Solid Tints and Dyes (except Pink I and II)	\$15	\$15
Plastic Gradient Dye	\$17	\$17
UV Protection	\$16	\$16
Polycarbonate Lenses (for adults) Polycarbonate lenses are covered-in-full for dependent children.	\$31	\$35
Anti-reflective Coating	\$41	\$41
Photochromic Lenses	\$70	\$82
Standard Progressive	N/A	\$55
Premium Progressive	N/A	\$95 – \$105
Custom Progressive	N/A	\$150 – \$175

¹Prices shown reflect the standard plastic price for each respective category. Premium lens enhancement prices may vary. Prices are valid only through VSP network doctors and are subject to change without notice.

SOLID TINTS AND DYES

Solid color tints and dyes are not only fashionable, they also reduce the amount of light coming through the lenses.

PLASTIC GRADIENT DYES

Gradient dyes are usually dark at the top and gradually lighten toward the bottom of the lenses.

UV PROTECTION

The combination of UV protection that's built into lenses and applied as a coating can block 98% – 100% of transmitted and reflected UVA and UVB rays.

POLYCARBONATE LENSES

Polycarbonate lenses are one of the thinnest, lightest, and most impact-resistant materials available. Plus, they provide UV protection and scratch resistance.

ANTI-REFLECTIVE COATING

Anti-reflective coating can reduce eyestrain caused from glare, reflections, and the "halos" you see around lights at night. Plus, it helps protect your lenses from scratches and smudges, and can repel dust and water.

PHOTOCHROMIC LENSES

Photochromic lenses automatically darken when exposed to sunlight and lighten when out of sunlight.

PROGRESSIVE LENSES

Unlike traditional bifocal and trifocal lenses that have lines, progressive lenses are line-free. Also, the power gradually changes with distance.



QUESTIONS?

Call your agent today.

IMPORTANT INFORMATION

To be eligible for an Arkansas Blue Cross dental insurance policy, you must be an Arkansas resident. Other eligibility rules may apply. Dependents who become ineligible may continue their coverage by completing a new dental plan application within 30 days of becoming ineligible for coverage under their existing policy. At that time, the policyholder will be credited for any waiting and frequency periods met and will begin a new dental benefit year; however, credit will not be given for a met deductible. This outline of coverage provides a brief description of the important features of the dental insurance policy. The outline is not the policy, and only the actual policy provisions will control. Children age 26 and above are not eligible to apply for coverage on a parent's plan. These policies are represented by the following form numbers:

Dental Pediatric Plan

- 64-314 (Off Marketplace);
- 64-315 (On Marketplace)

Dental Silver Plan

- 64-316 (Off Marketplace);
- 64-317 (On Marketplace)

Dental Gold Plan

- 64-318 (Off Marketplace);
- 64-319 (On Marketplace)

Dental Gold Plus Vision Plan

- 64-320 (Off Marketplace);
- 64-321 (On Marketplace)

The policy itself sets forth in detail the rights and obligations of both you and the insurance company. It is, therefore, important that you read the policy carefully. This policy is guaranteed renewable as long as you reside in Arkansas. The company may change the established premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification.

Dental Gold plans have an 85 percent actuarial value (AV); Dental Silver plans have a 70 percent AV.

WAITING PERIODS

For individuals age 19 or older, some dental plans contain waiting periods prior to certain services being covered. Once the waiting period is satisfied, those services are payable, subject to all other terms, conditions, exclusions and limitations of the policy.

PEDIATRIC BENEFIT LIMITATIONS | for Pediatric, Silver, Gold, Gold Plus Vision Plans

Routine dental exams, prophylaxis, fluoride treatments, and bitewing x-rays for dependent children under age 19 are limited to two in a calendar year; comprehensive dental evaluations are limited to one per covered person every 24 months; sealants for permanent first and second molars

only and limited to one sealant per lifetime; stainless steel crowns for those under the age of 14, crown lengthening, and guided tissue regeneration are limited to one per tooth per lifetime. Removable prosthetics including complete and partial dentures are limited to one per each five-year period.

ADULT BENEFIT LIMITATIONS | for Silver, Gold and Gold Plus Vision Plans

Routine dental exams, prophylaxis are limited to two in a calendar year; bitewing x-rays (one occurrence of two, three, four or eight vertical bitewings for adults 19 and older) are limited to one in a calendar year; comprehensive dental evaluations are limited to one per covered person every 24 months; full mouth radiographs, single crowns, crown buildups including pins are limited to one per each five-year period; root canal therapy is limited to one per tooth per lifetime.

ADULT BENEFIT LIMITATIONS | for Gold and Gold Plus Vision Plans

Rebasing/relining of full or partial dentures is limited to one in a three-year period; inlays and onlays for treatment of decay, single crowns, removable prosthetics, partial denture retainers, post and cores are limited to one per each five-year period; crown lengthening, and guided tissue regeneration are limited to one per tooth per lifetime.

PEDIATRIC AND ADULT BENEFIT EXCLUSIONS | for all Plans

Orthodontic services; services, procedures or supplies not dentally necessary; services or procedures not prescribed or rendered by a dentist; services or supplies collectible under Worker's Compensation; services for conditions for which treatment is provided by federal or state government or are provided without cost; accidental injuries, injuries or diseases caused by war; cosmetic services; prescription drugs; local or block anesthesia when billed separately; experimental or investigational services; services provided by an immediate relative.

COVERED PERSONS 19 AND OLDER BENEFIT EXCLUSIONS | for all Plans

Re-evaluation limited, problem focused and comprehensive periodontal evaluation; oral surgery procedures for jaw deformities, resections, etc; apically positioned flap procedure; enamel microabrasion; odontoplasty; sleep apnea appliances;

biologic materials to aid in soft and osseous tissues regeneration; provisional pontic and titanium pontic; provisional retainer crown; pediatric partial denture-fixed; mobilization of erupted or malpositioned tooth to aid eruption; cytology sample collection; fixed partial denture resin crowns, retainer or pontics on permanent teeth; orthodontic treatment for any reason is not covered; hospital or anesthesia fees due to the management of the patient; hospital facility fees for dental services; biopsy of oral tissue; sutures of small wounds and complicated sutures; occlusal guard.

GENERAL VISION | Coverage Limitations

All vision benefits are based on the frequency periods, copayments and discounts stated in the policy. Vision exams and materials are further limited to the allowable charge as determined by the company. Any amount over the allowable charge is the covered person's responsibility.

The following items are excluded under this plan:

- Two pairs of glasses instead of bifocals
- Replacement of lenses, frames or contacts
- Medical or surgical treatment
- Orthoptics, vision training or supplemental testing

Items not covered under the contact lens coverage:

- Insurance policies or service agreements
- Artistically painted or nonprescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification, polishing or cleaning

VISION | Out-of-Network Reimbursement

If you choose an out-of-network vision provider, you pay the provider directly for all charges and then submit a claim for reimbursement. Out-of-network reimbursement includes:

Eye exam – \$45;
Single vision lenses – \$30;
Bifocals – \$50;
Progressives – \$50;
Trifocals – \$65;
Lenticular – \$100;
Frame – \$70;
Elective contact lenses – \$85;
Necessary contact lenses – \$210

Our Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276. **CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.