Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

2024 DENTAL INSURANCE PLANS

FOR YOU AND YOUR FAMILY

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MPI 8598.5 09/23 AG

DENTAL

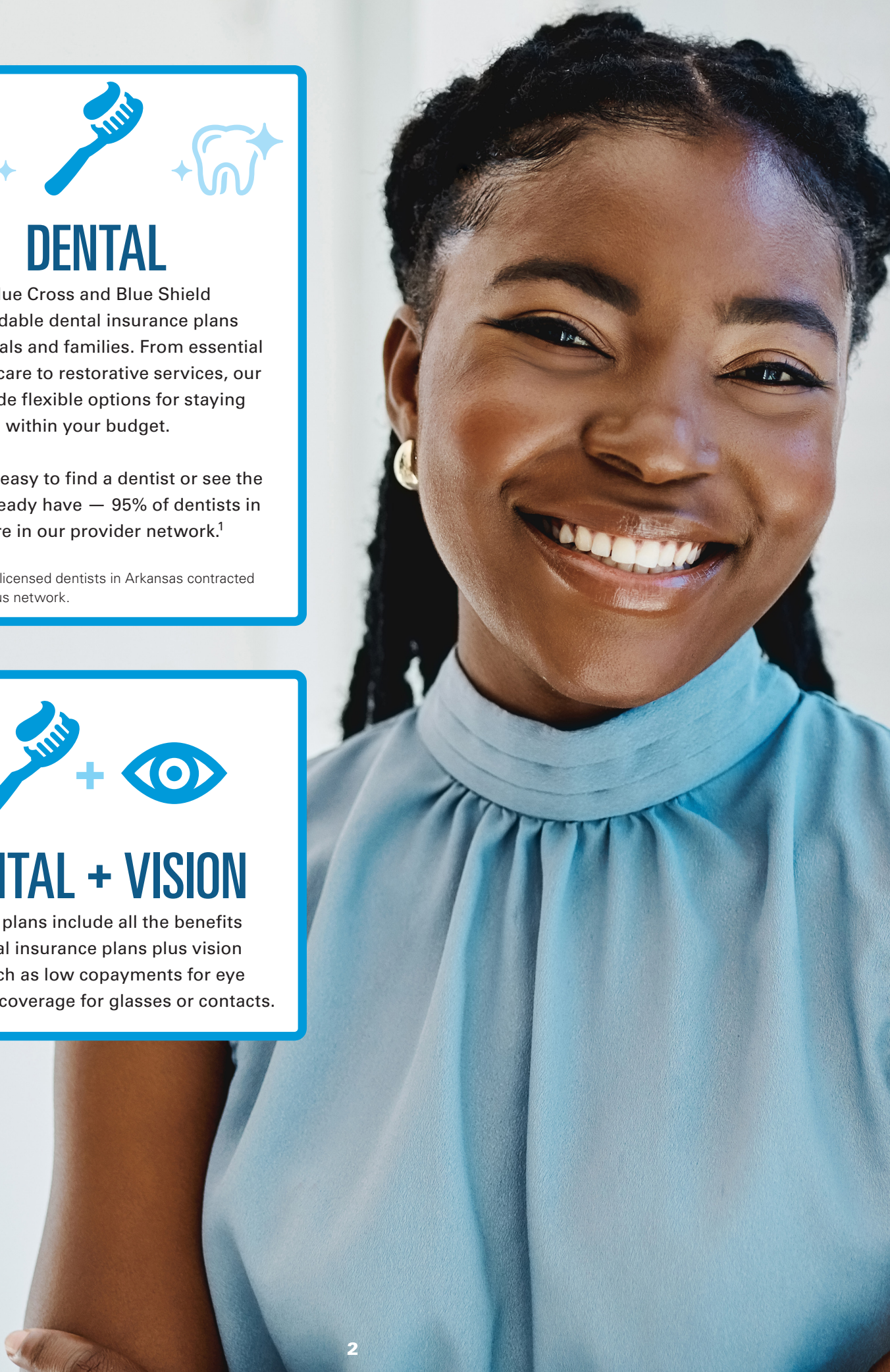
Arkansas Blue Cross and Blue Shield offers affordable dental insurance plans for individuals and families. From essential preventive care to restorative services, our plans provide flexible options for staying healthy and within your budget.

We make it easy to find a dentist or see the one you already have — 95% of dentists in Arkansas are in our provider network.[1]

[1]Percentage of licensed dentists in Arkansas contracted in our PPO Plus network.

DENTAL + VISION

Our combo plans include all the benefits of our dental insurance plans plus vision benefits such as low copayments for eye exams and coverage for glasses or contacts.



Dental Xtra

Dental health has a big impact on your overall health, especially if you have medical conditions affected by oral health. Through the Dental Xtra program, members with eligible conditions get additional benefits that can help you live healthier and save on medical costs. Dental Xtra benefits are covered 100% when you see a participating provider — there are no additional out-of-pocket expenses and Dental Xtra services don't apply toward your calendar-year maximum.

You're automatically enrolled if you have medical and dental plans with Arkansas Blue Cross and you have an eligible medical condition.

Eligible medical conditions	Two additional cleanings or periodontal maintenance visits, plus:		
	Periodontal scaling covered 100%	Enhanced cleaning to remove excess plaque buildup	Oral health screenings; fluoride treatments
Chronic obstructive pulmonary disease	✓	✓	
Coronary artery disease	✓	✓	
Diabetes	✓	✓	
End-stage renal disease	✓	✓	
Metabolic syndrome	✓	✓	
Oral, head and neck cancers		✓	✓
Pregnancy	✓	✓	
Sjögren's syndrome		✓	✓
Stroke	✓	✓	

Calendar Year Rollover

Gold and Platinum members 19 or older can save a portion of unused benefit dollars to use in future years for unexpected services.

Over time, you can reach up to $2,000 in annual benefits if you have a Gold plan or up to $2,750 if you have a Platinum plan.

Here's how it works:

	GOLD	PLATINUM
Yearly threshold amount	$500	$700
Amount you can roll over to next year	$350	$500
Maximum accumulated rollover	$1,000	$1,250

Byte Clear Aligners

Through an exclusive discount for Arkansas Blue Cross dental members, you can save up to $400 on Byte® Clear Aligners, a convenient, at-home treatment for straightening teeth. Byte's treatment system can cut treatment time in half and costs thousands less than braces on average. It's also HSA- and FSA-eligible.

Dental Plans

	PEDIATRIC	SILVER	
	Child Only (Age 0-18)	**Child (Age 0-18)**	**Adult (Age 19+)**
Plan year maximum	Unlimited	Unlimited	$1,000
Out-of-pocket maximum	$400	$400 for one child; $800 for two or more children	Unlimited
Waiting periods[2]	None	None	6 months (minor restorative)
Rollover benefit	None	None	
Dental Xtra benefit	Yes	Yes	
CALENDAR YEAR BENEFITS	**MEMBER PAYS (IN NETWORK)**		
Deductible	$20	$50	
Diagnostic and preventive coverage Exams, prophylaxis (teeth cleaning), X-rays (pediatric plan also covers fluoride treatment and sealants)	0% coinsurance after deductible	10% coinsurance after deductible	
Minor restorative coverage Fillings, endodontics (root canals), oral surgery, extractions, periodontics (treatment for gum disease)	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible
Major restorative coverage • All ages — crowns, partials and dentures, surgical periodontics • 19 and over — bridges, inlays, and onlays	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance (re-cementations, repairs and adjustments only)
Implants	Not covered	Not covered	
Orthodontics	Not covered	Not covered	
Monthly rates per person	**$34.28**	**$24.66**	**$23.25**

Note: Information in grid represents in-network benefits.

[2]The six-month waiting period for minor restorative services (adult Silver, Gold or Platinum plans) and the six-month waiting period for major restorative services (adult Gold or Platinum plans) 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.

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

GOLD		PLATINUM	
Child (Age 0-18)	**Adult (Age 19+)**	**Child (Age 0-18)**	**Adult (Age 19+)**
Unlimited	$1,000	Unlimited	$1,500
$400 for one child; $800 for two or more children	Unlimited	$400 for one child; $800 for two or more children	Unlimited
None	6 months (minor and major restorative)	None	6 months (minor and major restorative)
None	Yes	None	Yes
Yes		Yes	
MEMBER PAYS (IN NETWORK)			
$35		$20	
0% coinsurance after deductible		0% coinsurance after deductible	No coinsurance or deductible
20% coinsurance after deductible		20% coinsurance after deductible	
50% coinsurance after deductible		50% coinsurance after deductible	
Not covered	Covered	Not covered	Covered
Not covered		Not covered	
MONTHLY RATES (PER PERSON)			
$32.21	**$37.08**	**$34.28**	**$45.39**

Vision Coverage

Gold Plus Vision and Platinum Plus Vision Benefits

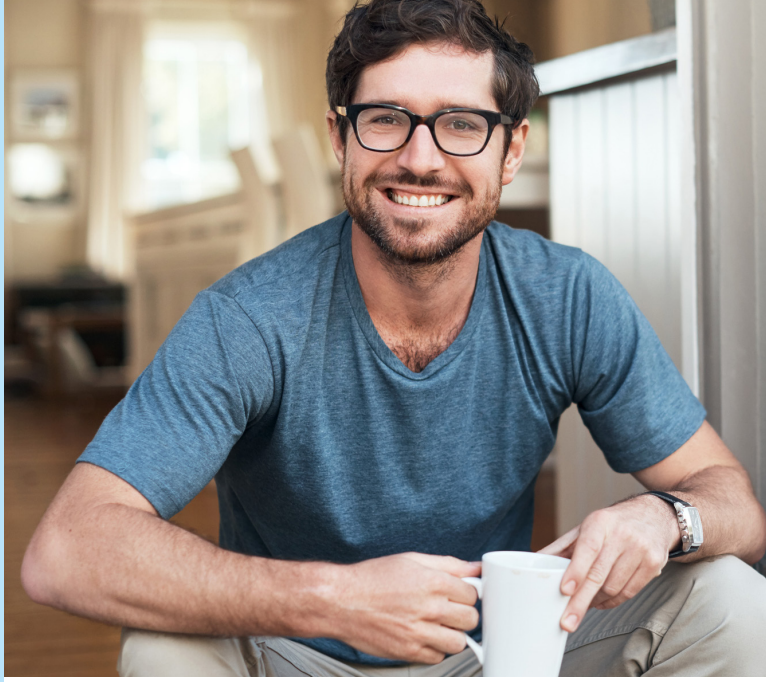
PLAN COVERAGE THROUGH A VSP NETWORK DOCTOR	
Benefit	**Description (Frequency: Every 12 months)**
Annual eye exam	• Eye exam covered in full after $10 copay

Lenses	• 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[3,4]
	• 20% savings on additional glasses or sunglasses, within 12 months of vision exam[4,5]

Frames	• Frames are covered in full[6] up to $125 allowance[4] ◦ 20% off any amount exceeding allowance[4]
Contact lenses	• 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 $60[4] • Find additional savings on contact lenses at **vsp.com**
VALUE-ADDED BENEFIT	
VSP Laser VisionCare℠ Program	• VSP-contracted laser centers provide discounts for laser surgery, including photo refractive keratectomy (PRK), Custom PRK, LASIK, Custom LASIK, and Intralase.[7] • 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.[8] • Find a VSP-contracted Laser VisionCare provider at **vsp.com**.

DENTAL GOLD PLUS VISION MONTHLY RATES (PER PERSON)			
Child (age 0-18)	**$38.61**	Adult (age 19+)	**$43.48**

DENTAL PLATINUM PLUS VISION MONTHLY RATES (PER PERSON)[10]			
Child (age 0-18)	**$40.87**	Adult (age 19+)	**$51.98**



In addition to all of the dental benefits, with Dental Gold Plus Vision and Dental Platinum 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[9]
- The freedom to choose any eye doctor[9]

To shop our stand-alone Vision plans, visit arkbluecross.com/vision.

[3]Most popular lens enhancements include progressives, anti-reflective, photochromics, polycarbonate, plastic dyes, and UV protection. All other lens enhancements also available at 20% savings.
[4]Based on applicable laws; benefits may vary by location.
[5]Discounts valid through any VSP network doctor within 12 months of the last covered eye exam.
[6]Less any applicable copay.
[7]Custom 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.
[8]The 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.
[9]It will cost more to visit an out-of-network eye doctor. To see which eye doctors are in the network, visit **vsp.com**.
[10]Platinum Plus Vision includes the SunCare benefit.

SunCare benefit: If a vision examination does not result in a need for corrective vision materials, you may use your vision materials benefits (frame and lens) to purchase nonprescription sunglasses from a participating provider's frame board. Nonprescription sunglasses purchased under this benefit exhaust your frame and lens benefits for the frequency period. This means if you use this benefit to purchase nonprescription sunglasses, you are not eligible for additional vision materials benefits until the completion of the next frequency period.

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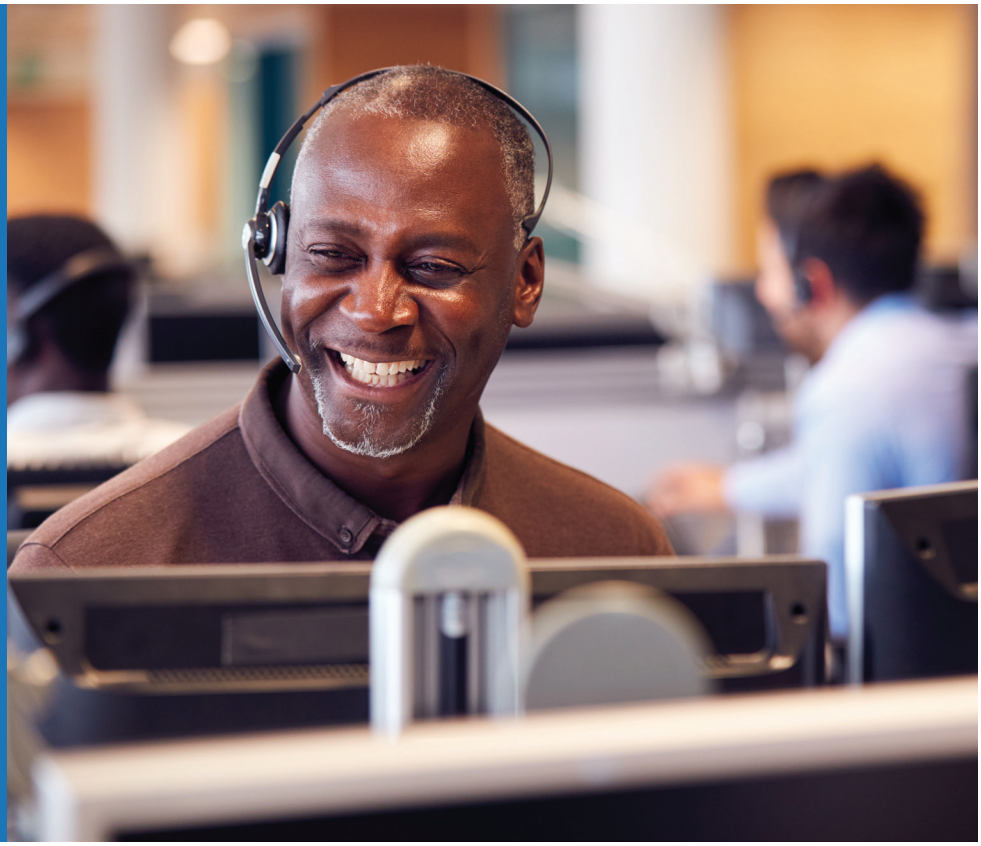
Most Popular Lens Enhancements

For Dental Gold Plus Vision and Platinum Plus Vision Plans

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

LENS ENHANCEMENT	Single Vision[11]	Multifocal[11]
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) Covered in full for dependent children (ages 18 and under)	$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

[11]Prices 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 made of 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.

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. This 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); **Dental Platinum** 64-364 (Off Marketplace), 64-365 (On Marketplace); **Dental Platinum Plus Vision** 64-366 (Off Marketplace), 64-367 (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.

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, Platinum and Platinum 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 and full mouth debridement are limited to one per covered person every 24 months; sealants for permanent first and second molars only and are limited to one sealant per tooth 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, Gold Plus Vision, Platinum and Platinum 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 and full mouth debridement are limited to one per covered person every 24 months; full-mouth radiographs and single crowns 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, Gold Plus Vision, Platinum and Platinum 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, crown buildups including pins, 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 workers' 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

Reevaluation-limited, problem-focused and comprehensive periodontal evaluation; oral surgery procedures for jaw deformities, resections, etc.; apically positioned flap procedure; enamel microbrasion; 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; 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

QUESTIONS?

Please contact your agent.

Or visit arkbluecross.com/dental.