Health Care Plan

Dental Coverage

Effective August 1, 2011, the new Enhanced Traditional Dental Plan provider network is Dental Network of America®, LLC (DNoA). Insert these replacement pages into ***Your Employee Benefits*** handbook dated November 19, 2007.

This section of your handbook answers these questions:

Health Care Plan - Dental Coverage

How does Dental coverage work?

The Traditional Dental benefits are provided for most dental services.

Traditional Dental benefits cover most dental services for you, your spouse or eligible same-sex domestic partner, and your eligible dependents. Benefits are paid at 100%, 90% or 50% of the covered expense (up to the allowed amount); depending on the service you receive. You do not have to satisfy a deductible. The maximum dental benefit payable in a calendar year effective January 1, 2008 is $1,850 for each individual.

Most orthodontic services are covered at 50%. There is a lifetime maximum of $2,200 for orthodontia for each covered person under age 19 effective January 1, 2008 with a maximum of $2,000.00 applicable to covered dental expenses for services provided prior to January 1, 2008.

Payments for covered dental services related to the repair of accidental injury to sound natural teeth due to a sudden unexpected impact from outside the mouth will not count against the annual benefit limit or the lifetime orthodontic limit. Regular co-payments will be required for all such services.

Information relating to your eligibility for Dental coverage is provided in the “Eligibility for Health Care Coverage” section.

Covered Expenses

Covered dental expenses are the "allowable amounts" that a dentist charges for services and supplies which are "necessary" for treatment of a dental condition customarily employed for treatment of that condition, and which are rendered in accordance with accepted standards of dental practice.

If you have a dental problem that can be treated in more than one way, the procedure that provides a cost-effective, professionally satisfactory result is covered.

Are dental services covered in an outpatient hospital setting?

Refer to the “Hospital-Surgical-Medical Coverage” section for information on dental services received at an outpatient hospital setting.

What Dental services are covered?

Expenses for dental services are covered at 100%, 90% or 50% of the Allowable Amount.

Services covered at 100%

These services are paid at 100% of the allowable amount:

- Routine oral exams and cleaning and scaling, but not more than twice for each covered person during any calendar year
- Four cleanings per calendar year if you have a documented history of periodontal disease
- One topical application of fluoride, provided that such treatment is only for enrollees under 15 years of age unless a specific dental condition makes such treatment necessary
- Space maintainers to replace prematurely lost teeth for covered children under age 19 (coverage will terminate the end of the day immediately preceding the covered child's 19th birthday)
- Emergency treatment to relieve dental pain
- Fabrication of fluoride trays and fluoride treatment applications for cancer patients undergoing radiation therapy of the head and neck.

Services covered at 90%

These services are paid at 90% of the allowable amount:

- Dental X-rays, including full mouth X-rays once each period of five consecutive calendar years, supplementary bitewing X-rays once in any calendar year for enrollees age 14 and younger; and once every two years for enrollees age 15 and older, and such other dental X-rays as required for the diagnosis of a specific treatment
- Extractions
- Oral surgery
- Fillings made of amalgam, silicate, acrylic, synthetic porcelain and composites to restore diseased or accidentally injured teeth
- General anesthetics and intravenous sedation when necessary and used with oral or dental surgery
- Periodontics and treatment of other gum or mouth tissue diseases
- Endodontics, including root canal therapy
- Injection of antibiotics by the attending dentist
- Repair or recementing of crowns, inlays, onlays, bridgework and dentures; or relining or rebasing dentures more than six months after installation, but not more than once in any period of 36 consecutive months
- Inlays, onlays, gold fillings or crown restorations but only when a tooth, as a result of extensive caries or fractures, cannot be restored with the filling materials described above
- Replacement of crowns more than three (3) years after installation of an initial or replacement crown if the crown has been damaged and cannot be made serviceable, or if there is recurrent decay under the existing crown or decay at a crown-to-natural-tooth margin that cannot be repaired by a direct-fill restoration
- Oral brush biopsy up to two (2) times per year per member over the age of 18.

Services covered at 50%

These services are paid at 50% of the allowable amount:

- Initial installation of fixed bridgework, including inlays and crowns as abutments
- Initial installation of partial or full removable dentures, including any attachments and adjustments during the six (6) months after installation.
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or to bridgework if:
  - The replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed
  - The existing denture or bridgework cannot be made serviceable and, if installed under this Plan, at least five years have passed since its installation
  - The existing denture is an immediate temporary denture and replacement of a permanent denture occurs within 12 months of the first installation of the immediate temporary denture
- Orthodontia (teeth straightening), as described in the "What is paid for orthodontia?" section and

Services covered under Hospital-Surgical-Medical coverage

- Benefits are provided under Hospital-Surgical-Medical coverage for cosmetic bonding of eight front teeth for children age eight through the end of the calendar year in which they become age 19 if required because of severe staining, but not more frequently than once in any period of three consecutive years.

What is the Enhanced Traditional Dental Plan?

The Enhanced Traditional Dental Plan is a nationwide dental provider network.

The Enhanced Traditional Dental Plan offers a nationwide dental provider network through an agreement between Blue Cross Blue Shield and **Dental Network of America (DNoA)**. When you receive services from a **DNoA** provider, your out-of-pocket expenses will be lower than those you would incur if you received services from a non-**DNoA** provider.

The **DNoA** Preferred Provider Network is a network of dentists in 50 states who have agreed to accept a discounted fee as full payment for covered services. Use of the **DNoA** Network is voluntary, but you may save money if you use a **DNoA** dentist. There is no commitment required, family members can switch back and forth at will. Since the **DNoA** dentist accepts less for covered services, your co-payment amounts will be lower, and you will not be billed for the balance of the charges above the **DNoA** approved amount. This schedule is typically 10-30% below the average charges of non-**DNoA** dentists. You also save money because **DNoA** provides a higher level of coverage for certain services. For example:

	Traditional	**DNoA**
Fillings	90%	100%
Root Canals	90%	100%
Gum Treatments	90%	100%
X-Rays	90%	100%
Extractions	90%	100%
Bridgework	50%	70%
Dentures	50%	70%
Orthodontics	50%	60%

Built-in Predetermination

The **DNoA** enhanced dental program requires predetermination for complex or expensive services ($200 or more).

However, if a **DNoA** dentist neglects to predetermine the covered service with BCBSM, you will not be responsible for the higher amount. For example, if a network dentist installed a crown without predetermining the case prior to treatment and BCBSM determined that a filling was an acceptable form of treatment, you would be responsible for only the co-payment for a filling, not the balance for the crown.

Traditional dental benefits remain the same if you use a non-network **DNoA** dentist. You can still save money if you use a participating dentist who has agreed to accept Blue Cross Blue Shield's maximum payment amount for covered services. However, you should always ask your dentist if he or she participates with **DNoA** because using a **DNoA** dentist will save you additional money and stretch your annual and lifetime maximums.

Finding a DNoA Network dentist is easy

There are generalist and specialist **DNoA** network dentists nationwide. Ask your current dentist if he/she is in the **DNoA** network. If the dentist is not in the network, you may locate a network dentist or nominate your dentist by submitting the dentist's name, address and phone number by calling:

Dental Network of America at 1-888-736-7794

If you wish to locate a **DNoA** dentist near where you live or work, you may find a list of **DNoA** providers at **www.bcbsm.com/bluedental.com** or by calling them at **1-888-736-7794**.

What is paid for orthodontia?

For eligible persons under age 19, Traditional Dental benefits are paid at 50% (60% for DNoA) of covered orthodontic services, up to an annual maximum per covered person.

Orthodontia is a special part of your Dental benefits. Benefits are provided for teeth-straightening programs for eligible persons, as long as continuous treatment begins before age 19.

Dental benefits are paid at 50% of the allowable amount for all covered services relating to orthodontic treatment, up to a $2,200 lifetime maximum per covered person effective January 1, 2008 with a maximum of $2,000 applicable to covered dental expenses for services provided prior to January 1, 2008. "Orthodontic treatment" includes preventive and corrective treatment of dental irregularities resulting from injury or the abnormal growth and development of teeth.

Covered services include:

- Diagnostic procedures and treatment, including oral exams related to orthodontia
- Surgical therapy
- Appliance therapy
- Functional/myofunctional therapy (when related to surgical therapy)

When is a treatment plan necessary?

A "treatment plan" must be filed in advance if charges are expected to be $200 or more.

If the estimated charges are less than $200 or if emergency care is involved, your dentist need not obtain a predetermination of benefits, as described below. Once the work is completed, a claim form must be submitted.

If treatment of planned dental work is expected to be $200 or more, your dentist will need to file a predetermination of benefits or "treatment plan" with the claims processor before treatment begins—unless emergency care is necessary. The claims processor then can authorize payments before your dentist begins work, and you will know in advance exactly how much your Dental coverage will pay.

A treatment plan works as follows:

- Your dentist decides what treatment is needed and describes it on the appropriate form, along with an estimate of treatment charges. This form is available from the claims processor
- You and your dentist then will be notified what portion of the total expenses will be paid by your Dental coverage. The claims processor will take into account any alternatives that may be used to accomplish the same result
- After the dental work is complete, you or your dentist should send the claim back to the claims processor for payment
- If a treatment plan is required but not submitted in advance, the claims processor reserves the right to determine the benefits payable, taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice.

What Dental services are not covered?

Under the Traditional Plan, no benefits are paid for the dental services below.

Under the Traditional Plan, certain dental expenses are not covered. These include:

- Benefits payable by your other Health Care coverages
- Work not done by a dentist, except scaling and cleaning of teeth and topical application of fluoride by a licensed dental hygienist under a dentist's supervision
- Veneers for crowns or pontics on teeth, other than the 10 upper and lower anterior teeth
- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
- Prosthetic devices (including bridges), crowns, inlays, onlays and their fitting, if you were not covered when they were ordered or if they are not installed or delivered within 60 days after the day your coverage ends
- Replacement of lost, missing or stolen prosthetic devices
- Failure to keep a scheduled visit with the dentist
- Replacement or repair of an orthodontic appliance
- Charges for services which are compensated under Workers' Compensation
- Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer
- Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage
- Charges for services or supplies, which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist
- Charges for services or supplies which do not meet accepted standards of dental practice and that are considered experimental
- Services or supplies received as a result of war, declared or undeclared
- Services or supplies furnished or payable by any government or governmental agency, or any governmental program or law under which you could be covered, unless payment is legally required
- Duplicate appliances
- Charges for completion of any insurance forms
- Sealants and oral hygiene and dietary instruction
- A plaque control program
- Implantology
- Services or supplies for periodontal splinting

How does coverage under an alternative Dental plan work?

In some areas of the country, you may choose to receive Dental coverage through an alternative dental plan.

If you live in an area served by an alternative dental plan which is approved by Ford and the UAW, you may elect Dental coverage under that plan in place of the Traditional Plan's coverage.

With the Hourly Rolling Enrollment process, there is no longer a specific enrollment period. You may change your dental plan election during any month of the year (provided 12 months have elapsed since your last change).

To make a change, call the NESC at 1-800-248-4444 or go to myfordbenefits.com. You will receive a confirmation statement in the mail anytime you make a change. Your election takes effect on the 1st day of the 2nd month following your election.

For detailed information on the availability of and the coverage provided by an alternative dental plan, contact the **NESC or go to myfordbenefits.com** to request benefit summaries and determine which plans you are eligible to choose from. Detailed information related to the plan can be provided by the dental carrier. The benefit summaries include the phone number to the carrier.

Refer to the section "Eligibility for Health Care Coverage" for more details on changing your election.