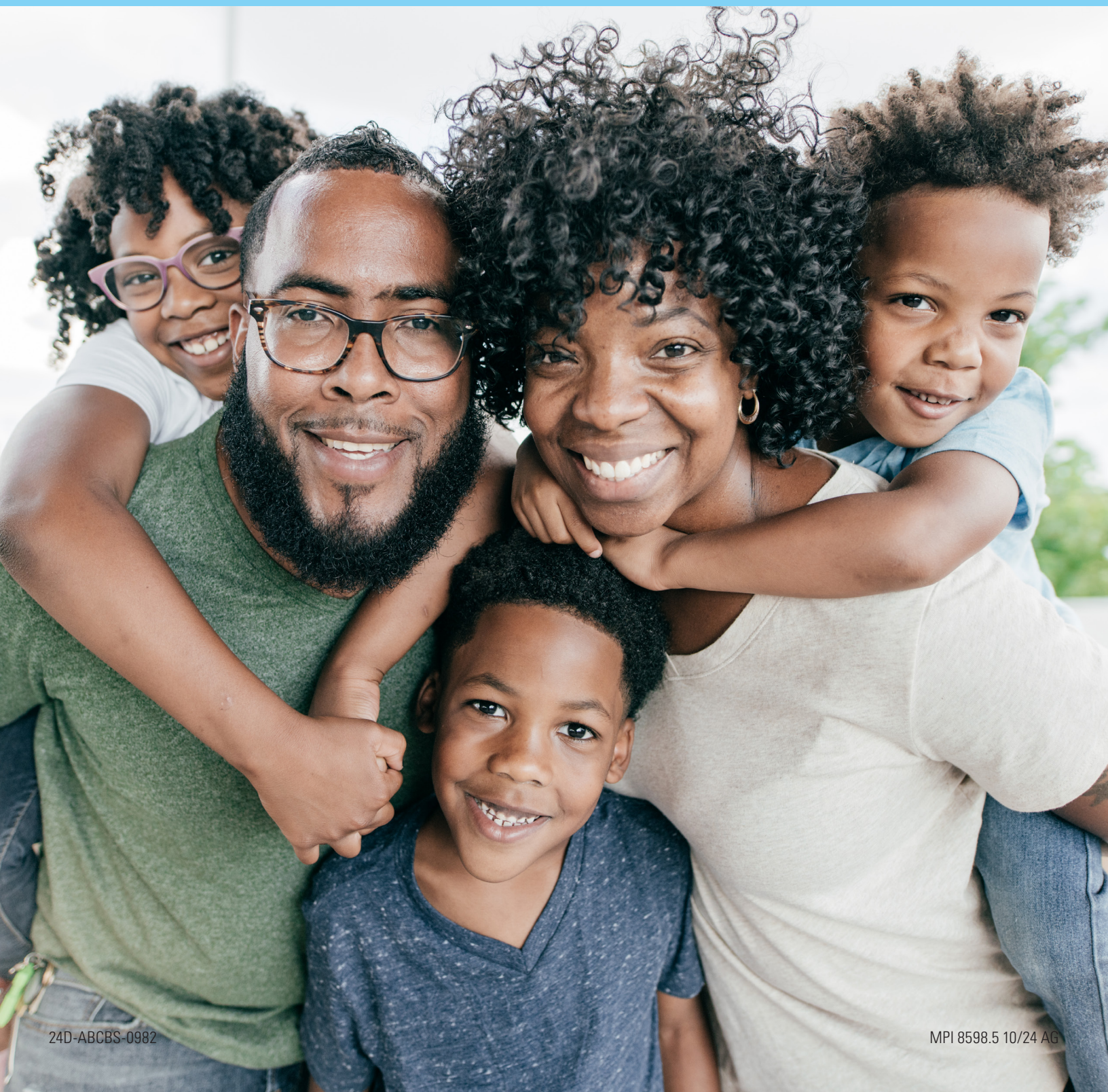
Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

2025 DENTAL INSURANCE PLANS

FOR YOU AND YOUR FAMILY



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Arkansas Blue Cross and Blue Shield offers best-in-class dental and vision insurance coverage, whether you're only looking for a dental plan or one of our unique Dental + Vision combo plans.

Dental

Our dental plans provide the coverage and benefits you need to live healthier and save money. From our highly affordable Silver plan to the new, feature-rich Platinum Premium plan, we offer a number of flexible coverage options that meet any need and budget. And if you have an eligible medical condition affected by oral health, you'll want to take advantage of our unique Dental Xtra℠ program.

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.

New for 2025
Platinum Premium Plan

Our new Platinum Premium plan features a **$2,500 calendar-year maximum** benefit and **orthodontia coverage for children**.

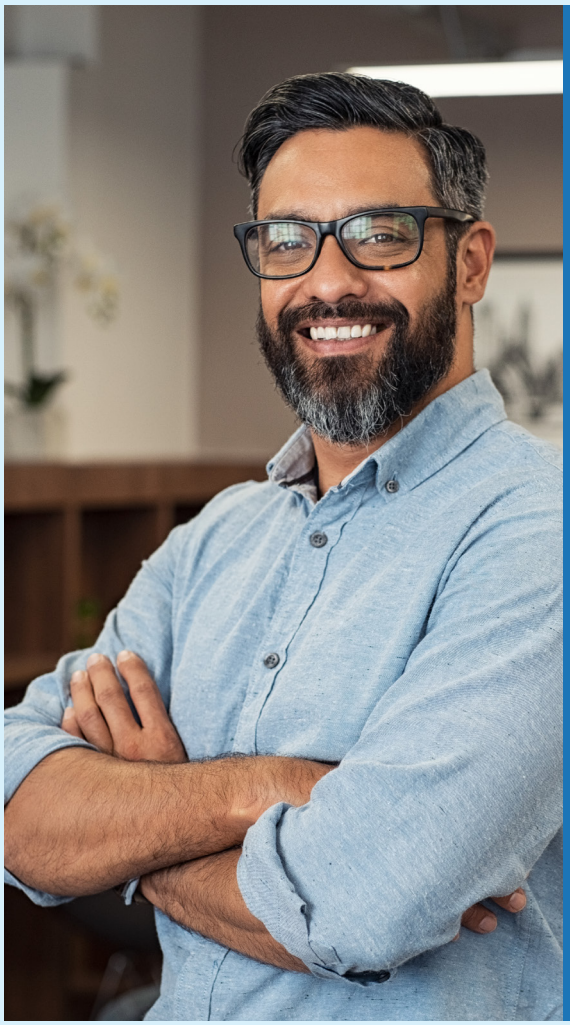
Dental Xtra

Our Dental Xtra program provides additional benefits to members with eligible medical conditions that can reduce the severity of these conditions and lower the medical costs associated with them. These benefits are covered 100% when you visit an in-network provider. There are no waiting periods, and program services don't count toward your annual maximum.

You're automatically enrolled if you have medical and dental plans with Arkansas Blue Cross and 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	✓	✓	

Dental Plan Features



A large provider network in Arkansas and nationwide

You have access to a large network of dentists in Arkansas and nationwide—nearly 90% of dentists in Arkansas are in our provider network[1] — and no referrals or authorizations are necessary when you need to see a specialist. Our network dentists agree to reduced fees for our members, which saves you money.

24/7 emergency care

If you have a dental emergency and can't contact your dentist, you have 24/7 access to virtual dental visits[2] at TeleDentistry.com at no extra cost.

Member portal

You can access your dental and medical benefit info and ID card 24/7 in the Blueprint Portal mobile app or at blueprintportal.com.

Calendar Year Rollover

Gold, Platinum and Platinum Premium members ages 19 and 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, up to $2,750 if you have a Platinum plan and up to $4,000 with a Platinum Premium plan.

Here's how it works:

	GOLD	PLATINUM	PLATINUM PREMIUM
Yearly threshold amount	$500	$700	$900
Amount you can roll over to next year	$350	$500	$700
Maximum accumulated rollover	$1,000	$1,250	$1,500
Total potential annual benefit	**$2,000**	**$2,750**	**$4,000**

[1]Percentage of licensed dentists in Arkansas contracted in our PPO Plus network.
[2]Limit two visits per calendar year. Virtual visits count toward your plan's annual maximum.

Pediatric Dental Plans (Ages 0-18 Years)

	PEDIATRIC	SILVER	GOLD	PLATINUM	PLATINUM PREMIUM
Calendar year maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-pocket maximum	$425 for one child; $850 for two or more children	$425 for one child; $850 for two or more children	$425 for one child; $850 for two or more children	$425 for one child; $850 for two or more children	$425 for one child; $850 for two or more children
Waiting periods	None	None	None	None	Minor/major restorative: none Orthodontia: 12 months
Deductible (individual)	$20	$50	$35	$20	$20
CALENDAR YEAR BENEFITS	**YOU PAY (IN-NETWORK COINSURANCE AFTER THE DEDUCTIBLE[3])**				
Diagnostic and preventive coverage	0%	10%	0%	0%	0%
Minor restorative coverage	20%	30%	20%	20%	20%
Major restorative coverage	50%	50%	50%	50%	50%
Implants	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontia	Not covered	Not covered	Not covered	Not covered	50%
Orthodontia lifetime maximum	N/A	N/A	N/A	N/A	$1,000
ADDITIONAL BENEFITS					
Rollover	N/A	N/A	N/A	N/A	N/A
Dental Xtra	Included	Included	Included	Included	Included
RATES					
Dental plans	**$34.28**	**$24.66**	**$32.21**	**$34.28**	**$41.28**
Dental + Vision plans	N/A	N/A	**$38.61**	**$40.87**	**$47.87**

- **DIAGNOSTIC AND PREVENTIVE COVERAGE** includes exams, prophylaxis (teeth cleaning), X-rays, fluoride treatment and sealants.
- **MINOR RESTORATIVE COVERAGE** includes fillings, endodontics (root canals), oral surgery, extractions and periodontics (treatment for gum disease).
- **MAJOR RESTORATIVE COVERAGE** includes crowns, partials and dentures and surgical periodontics.

Adult Dental Plans (Ages 19 Years and Older)

	SILVER	GOLD	PLATINUM	PLATINUM PREMIUM
Calendar year maximum	$1,000	$1,000	$1,500	$2,500
Out-of-pocket maximum	None	None	None	None
Waiting periods[4]	Minor restorative: 6 months	Minor/major restorative: 6 months	Minor/major restorative: 6 months	Minor restorative: 6 months Major restorative: 12 months
Deductible (individual)	$50	$35	$20	$20
CALENDAR YEAR BENEFITS	**YOU PAY (IN-NETWORK COINSURANCE AFTER THE DEDUCTIBLE**[3]**)**			
Diagnostic and preventive coverage	10%	0%	0% (no deductible)	0% (no deductible)
Minor restorative coverage	25%	20%	20%	20%
Major restorative coverage	50% Re-cementations, repairs and adjustments only	50%	50%	50%
Implants	Not covered	Covered	Covered	Covered
Orthodontia	Not covered	Not covered	Not covered	Not covered
ADDITIONAL BENEFITS				
Rollover	Not included	Included	Included	Included
Dental Xtra	Included	Included	Included	Included
RATES				
Dental plans	**$23.25**	**$37.08**	**$45.39**	**$53.89**
Dental + Vision plans	N/A	**$43.48**	**$51.98**	**$60.48**

- **DIAGNOSTIC AND PREVENTIVE COVERAGE** includes exams, prophylaxis (teeth cleaning) and X-rays.
- **MINOR RESTORATIVE COVERAGE** includes fillings, endodontics (root canals), oral surgery, extractions and periodontics (treatment for gum disease).
- **MAJOR RESTORATIVE COVERAGE** includes crowns, partials and dentures, surgical periodontics, bridges, inlays and onlays.

[3]Information in grid represents in-network benefits. Coinsurance of 25% for diagnostic and preventive coverage, 40% for minor restorative coverage, and 70% for major restorative coverage applies to services provided by out-of-network providers.
[4]If 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 Arkansas Blue Cross policy, the six-month waiting periods for minor restorative services for adult Silver, Gold, Platinum and Platinum Premium plans, and major services for adult Gold and Platinum plans, will be waived. For Platinum Premium plans, the 12-month waiting period will be reduced to six months. You must show proof of prior continuous comparable dental insurance by providing a copy of your previous dental policy Certificate of Coverage and benefit schedule, which lists the coverage for services provided.

Vision Benefits

For Dental Plus Vision plans

With **Dental Gold Plus Vision**, **Dental Platinum Plus Vision** and **Dental Platinum Premium Plus Vision**, you get comprehensive dental benefits, plus:

- Coverage for eye examinations and eyeglasses or contact lenses
- Significant savings when visiting an in-network eye doctor or eye care center[5]
- The freedom to choose any eye doctor[5]

If you're looking for a standalone vision plan, visit **arkbluecross.com/vision**. Vision benefits are provided by Vision Service Plan (VSP).

PLAN COVERAGE THROUGH A VSP NETWORK DOCTOR (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.[6,7] • 20% savings on additional glasses or sunglasses, within 12 months of vision exam.[7,8]
Frames	• Frames are covered in full[9] up to $125 allowance.[7] • 20% off any amount exceeding allowance.[7]
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.[7] • Find additional savings on contact lenses at **vsp.com**.
VALUE-ADDED BENEFITS	
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.[10] • 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.[11] • Find a VSP-contracted Laser VisionCare provider at **vsp.com**.
SunCare[12]	• 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.

Lens Enhancements

For Gold Plus Vision, Platinum Plus Vision and Platinum Premium Plus Vision plans

Most lens enhancements (listed below) are covered after a copay, saving members an average of 20%-25%:

- **SOLID TINTS AND DYES** are fashionable and reduce the amount of light coming through the lenses.
- **PLASTIC GRADIENT DYES** are usually dark at the top and gradually lighten toward the bottom of the lenses.
- **UV PROTECTION** built into lenses and applied as a coating can block 98%-100% of transmitted and reflected UVA and UVB rays.
- **POLYCARBONATE LENSES** are made of one of the thinnest, lightest, and most impact-resistant materials available. They also provide UV protection and scratch resistance.
- **ANTI-REFLECTIVE COATING** can reduce eyestrain caused by glare, reflections and the "halos" you see around lights at night. It also protects your lenses from scratches and smudges and repels dust and water.
- **PHOTOCHROMIC LENSES** automatically darken when exposed to sunlight and lighten when out of sunlight.
- **PROGRESSIVE LENSES** are line-free, unlike traditional bifocal and trifocal lenses.

LENS ENHANCEMENT	Single Vision[13]	Multifocal[13]
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

[5]It will cost more to visit an out-of-network eye doctor. To see which eye doctors are in the network, visit vsp.com.
[6]Popular lens enhancements include progressives, anti-reflective, photochromic, polycarbonate, plastic dyes, and UV protection. All other lens enhancements are available at 20% savings.
[7]Based on applicable laws, benefits may vary by location.
[8]Discounts are valid through any VSP network doctor within 12 months of the last covered eye exam.
[9]Less any applicable copay.
[10]Custom LASIK coverage is only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member.
[11]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.
[12]Platinum Plus Vision and Platinum Premium Plus Vision include the SunCare benefit.
[13]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.

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex to include discrimination on the basis of sexual orientation and gender identity; sex stereotypes; sex characteristics (including intersex traits); and pregnancy or related conditions.
ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.
ATENCIÓN: si habla español, Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.
CHÚ Ý: Nếu bạn nói Tiếng Việt, Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

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 product brochure provides a brief description of the important features of the dental insurance policy. This brochure 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** 64-316 (Off Marketplace), 64-317 (On Marketplace); **Dental Gold** 64-318 (Off Marketplace), 64-319 (On Marketplace); **Dental Gold Plus Vision** 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) **Dental Platinum Premium** 64-400 (Off Marketplace), 64-401 (On Marketplace); **Dental Platinum Premium Plus Vision** 64-402 (Off Marketplace), 64-403 (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 all 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 all 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, Platinum Plus Vision, Platinum Premium and Platinum Premium 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 (except for Platinum Premium and Platinum Premium Plus Vision); 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.