

## Socorro ISD

Monthly Premium Rates	
Single	\$ 34.33
Single + Spouse	\$ 65.89
Single + Child(ren)	\$ 81.33
Family	\$111.48

**Plan Effective: 01/01/2024-12/31/2024**

**The following is a listing of common services available through your BlueCare Dental PPO network. The member's share of the cost is determined by whether care is received from a contracting or non-contracting provider.**

This information only provides highlights of this program. Please refer to the BlueCare Dental Certificate for additional benefit information. *Passive PPO's provide identical benefits for 'contracting' and 'non-contracting' providers.*

### D E N T A L B E N E F I T H I G H L I G H T S

<b>Program Basics</b>	<b>Contracting Provider</b>	<b>Non-Contracting Provider* U&amp;C 90th</b>
<b>Benefit Period Maximum:</b> Calendar Year	\$2,000	\$2,000
<b>Deductible:</b> Calendar Year	\$50.00 Individual \$150.00 Family	\$50.00 Individual \$150.00 Family
<b>Three Month Deductible Carryover Applies</b>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<b>Prior Carrier Deductible Credit Applies</b>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>Services</b>		
<b>Diagnostic Services (Deductible does not apply)</b> Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	100%	100%
<b>Preventive Services (Deductible does not apply)</b> Prophylaxis (cleanings) Topical fluoride applications	100%	100%
<b>Diagnostic Radiographs (Deductible does not apply)</b> Full-mouth and panoramic films Bitewing films Periapical films	100%	100%
<b>Miscellaneous Preventive Services (Deductible does not apply)</b> Sealants Space maintainers	100%	100%
<b>Basic Restorative Dental Services</b> Amalgams Resin-based composite restorations	80%	80%
<b>Non-Surgical Extractions</b> Removal of retained coronal remnants Removal of erupted tooth or exposed root	80%	80%

## PPO-SISD High

<p><b>Non-Surgical Periodontic Services</b>                      Periodontal scaling and root planing                      Full-mouth debridement                      Periodontal maintenance procedures</p>	50%	50%
<p><b>Adjunctive Services</b>                      Palliative treatment (emergency)                      Deep sedation / general anesthesia</p>	80%	80%
<p><b>Endodontic Services</b>                      Therapeutic pulpotomy and pulpal debridement                      Root canal therapy                      Apexification/recalcification</p>	50%	50%
<p><b>Oral Surgery Services</b>                      Surgical tooth extractions                      Alveoloplasty and vestibuloplasty                      Excision of benign odontogenic tumor/cyst                      Excision of bone tissue                      Incision and drainage of an intraoral abscess                      (Bony impactions typically covered under medical plan)</p>	80%	80%
<p><b>Surgical Periodontal Services</b>                      Gingivectomy or gingivoplasty and gingival flap procedures                      Clinical crown lengthening                      Osseous surgery                      Osseous grafts                      Soft tissue grafts/allografts                      Distal or proximal wedge procedure</p>	50%	50%
<p><b>Major Restorative Services</b>                      Single crown restorations                      Inlay/onlay restorations                      Labial veneer restorations                      Crowns placed over implants</p>	50%	50%
<p><b>Prosthetic Services</b>                      Complete and removable partial dentures                      Denture reline/rebase procedures                      Fixed bridgework                      Prosthetics placed over implants                      Implants Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	50%	50%
<p><b>Miscellaneous Restorative and Prosthetic Services</b>                      Prefabricated crowns                      Recementations                      Post and core, pin retention and crown/bridge repairs                      Adjustments</p>	50%	50%
<p><b>Orthodontics</b>  <b>Deductible Waived (standard)</b>                      Orthodontic Diagnostic Procedures and Treatment:                      Adults eligible: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p>	50%	50%

## PPO-SISD High

Dependent Children eligible:  No  Yes If  
yes age limitation: 26

\$1,500.00

\$1,500.00

### Lifetime Maximum Benefit per Participant

**Insured: Coordination of Benefits (COB):**  Birthday rule applies (**standard**)

**ASO: Coordination of Benefits (COB):**

Birthday rule (**standard**)

Gender rule

**Insured and ASO: Non-duplication of benefits (COB):**

Yes (all benefits combined not to exceed benefits of this program)

No (**standard** - all benefits combined not to exceed total charges)

### Claim filing time limit:

Within 365 days of the date of service (**standard**)

End of the year following the year of service

Two years from the date of service

Other (explain in additional provisions section below)

**Additional Provisions:** Changes from standard to non-standard benefits (**with CBSR / AdHoc approval**). Account Structure changes, i.e., new group & section numbers. Also, indicate renewal benefit changes and the effective date of that change.

CBSR for non-standard items #2022-02175-001

#### Preventive Services

1. Prophylaxis – limited to 3 per calendar year. Frequency limitation not combined with periodontal maintenance
2. Topical Fluoride Applications up to age 19; one per calendar year

#### Diagnostic Radiographs

3. Full Mouth / Panoramic X-Rays 1 per 36 months
4. Bitewing-xrays – 2 per calendar year

#### Miscellaneous Preventive Services

5. Space maintainers covered to age 19
6. Sealants up to age 16; one per 36 months
7. Palliative treatment (Emergency)

#### Basic Restorative Services

8. Resin-based Composite Restorations; 1 per tooth per 24 months

#### Non-Surgical Periodontal Services

9. Periodontal Scaling and Root Planning; 1 per quadrant per 24 months
10. Periodontal Maintenance cleanings do not count towards preventive cleaning limit
11. Chemical treatments or localized delivery of chemotherapeutic agents

#### Adjunctive Services

12. Consultations  
Exclusion #21 will be stated as : *Charges for email consultations, missed appointments, completion of a claim form or forwarding requested records or radiographic images*
13. Antibiotic Injections: Therapeutic Parenteral Drug, Single Administration (*D9610*), Therapeutic Parenteral Drugs, Two Or More Administrations, Different Medications (*D9612*), Infiltration of Sustained Release Therapeutic Drug Single or Multiple Sites (*D9613*)  
Exclusion #26 will be stated as : *Charges for local anesthesia, nitrous oxide analgesia, or other drugs or medications and/or their application*

#### Oral Surgery Services

14. Extraction of Full Bony impacted teeth covered under Dental. These procedures are not covered under the medical plan

#### Major Restorative Services

15. Major restorations; crowns, inlays/onlays,veneers are limited to one per tooth every 5 years

#### Prosthodontic Services

16. Complete dentures and removable partial dentures; one upper and one lower- once in any 5-year period
17. Denture reline/rebase procedures-limited to one procedure every 60 months
18. Guided tissue regeneration – covered

## PPO-SISD High

19. Implants - once per tooth every 5 years
20. Fixed bridgework once per every 5 years

Miscellaneous Restorative and Prosthodontic Services

21. Prefabricated stainless steel crowns - one per tooth every 5 year

### BlueMax Advantage – Available only for 151+

**Graduated Dental Benefit Maximum:** \$ Enter amount.

**Graduated Benefit Start Date:** Enter date.    **Number of Increments:** Enter number.

**In-Network Increment Amount:**    \$ Enter amount.

**Out-of-Network Increment Amount:** \$ Enter amount.

**Transfer-in (Takeover Credit):**  No     Yes: \$ Enter amount. and services being Transferred-In:

### Missing Tooth Exclusion applies:

#### Yes (standard)

An exclusion applies to expenses involving the replacement of teeth that were missing prior to the effective date of coverage, except when a participant has had continuous coverage for the following number of months under a group dental care contract with BCBSTX, a previous group dental contract or a combination of the two. Plans must include major services (prosthetic benefits).

- 24 months (standard)
- 99 months (exclusion permanently applies)

#### **Does exclusion apply to initial enrollees?**

- Yes (Same rules as above apply)
- No (Initial enrollees receive immediate coverage standard)

#### No Exclusion

All teeth covered beginning on first day of coverage

### Enhanced Dental Benefit - Yes (standard) No

Enhanced Benefit allows groups to provide additional dental benefits to members with specific medical conditions. The group must also have their medical coverage through BCBS.

#### Select Covered Conditions:

- Cardiovascular disease, Diabetes or Pregnancy (standard grouping)
- Pre-Diabetes (requires standard grouping)

Additional benefit for one of the following:

- Scaling & Root Planing
- Periodontal Maintenance
- Cleaning

**Apply toward annual maximum** -  Applies (standard)     Does not apply

Additional Enhanced Benefit provisions require Division of Insurance and/or CBSR approval.

Any customization should be noted in the Additional Provisions section.

### Preventive Services selected below will not apply to the annual maximum –

- Diagnostic Services

## PPO-SISD High

- Preventive Services
- Diagnostic Radiographs
- Miscellaneous Preventive Services

**Benefit Waiting Period** –  NO or  YES (the information below is required per group request) **Effective Date:** Enter date.

**NOTE: IF A BENEFIT WAITING PERIOD APPLIES; WAITING PERIOD WAIVED FOR EXISTING GROUP DENTAL PLANS AND/OR TRANSFERS GROUPS.**

Member must be continuously covered under this policy for [3,6,9,12,18,24] months before being eligible for the following Covered Services:

- Oral surgery
- Endodontics
- Non-Surgical Periodontal Services
- Surgical Periodontal Services
- Major Restorative Services
- Prosthodontic Services
- Miscellaneous Restorative and Prosthodontic Services
- Orthodontic Services

\*Each time you need dental care; you can choose to:

See a Contracting Provider	See a Non-Contracting Provider
<ul style="list-style-type: none"> <li>• Your out-of-pocket cost will generally be the least amount because BlueCare Providers have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses</li> <li>• You are not required to file claim forms</li> <li>• You are not balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists</li> </ul>	<ul style="list-style-type: none"> <li>• Your out-of-pocket cost may be greater because Non-Contracting Providers have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses</li> <li>• You are required to file claim forms)</li> <li>• You are balance billed for costs exceeding the BCBSTX Allowable Amount</li> <li>• Non-contracting provider reimbursement <b>U&amp;C 90th</b></li> </ul>

### EMPLOYEE INFORMATION

- This is a general summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.
- The following eligibility provisions apply:
  - Dependent children are covered to age 26. Disabled dependent children can be covered beyond age 26.
  - **Retirees are not eligible for coverage.**
  - Open enrollment - employees and/or dependents not presently covered may enroll for dental 31 days prior to the anniversary date.

When the course of treatment will be in excess of \$300, a predetermination request should be submitted to BCBSTX in advance of treatment.