BlueCare® Dental

PPO

BlueCross BlueShield of Texas

City of Cedar Park – Dental Plan

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.*

DENTAL BENEFIT HIGHLIGHTS

Effective 11/01/23

Program Basics	Contracting Provider	Non-Contracting Provider* U&C 90th
Benefit Period Maximum: Calendar Year	*$1,500*	*$1,500*
Deductible: Calendar Year	*$50* *$150 family*	*$50* *$150 family*

Services		
Diagnostic Services (Deductible does not apply) Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	*100%*	*100%*
Preventive Services (Deductible does not apply) Prophylaxis (cleanings) Topical fluoride applications	*100%*	*100%*
Diagnostic Radiographs (Deductible does not apply) Full-mouth and panoramic films Bitewing films Periapical films	*100%*	*100%*
Miscellaneous Preventive Services (Deductible does not apply) Sealants Space maintainers	*100%*	*100%*
Basic Restorative Dental Services Amalgams Resin-based composite restorations	*80%*	*80%*
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	*80%*	*80%*
Non-Surgical Periodontic Services Periodontal scaling and root planing Full-mouth debridement Periodontal maintenance procedures	*80%*	*80%*
Adjunctive Services	*80%*	*80%*

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Palliative treatment (emergency) Deep sedation / general anesthesia		
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	***80%***	***80%***
Oral Surgery Services Surgical tooth extractions Alveoloplasty and vestibuloplasty Excision of benign odontogenic tumor/cyst Excision of bone tissue Incision and drainage of an intraoral abscess	***80%***	***80%***
Surgical Periodontal Services Gingivectomy or gingivoplasty and gingival flap procedures Clinical crown lengthening Osseous surgery Osseous grafts Soft tissue grafts/allografts Distal or proximal wedge procedure Anatomical crown exposures	***80%***	***80%***
Major Restorative Services Single crown restorations Inlay/onlay restorations Labial veneer restorations Crowns placed over implants	***50%***	***50%***
Prosthodontic Services Complete and removable partial dentures Denture reline/rebase procedures Fixed bridgework Prosthetics placed over implants Implants Yes ☐ No☒	***50%***	***50%***
Miscellaneous Restorative and Prosthodontic Services Prefabricated crowns Recementations Post and core, pin retention and crown/bridge repairs Adjustments	***50%***	***50%***
Orthodontics **Deductible Waived (standard)** Orthodontic Diagnostic Procedures and Treatment: Adults eligible: ☐ No ☒ Yes Dependent Children eligible: ☐ No ☒ Yes If yes age limitation: 26 **Lifetime Maximum Benefit per Participant**	***50%*** ***$1,500***	***50%*** ***$ 1,500***

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

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ASO: Coordination of Benefits (COB):
☐ Birthday rule (standard)
☐ Gender rule

Non-duplication of benefits (COB):

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

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.
Surgical Implants – Not Covered

☐ **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 Provision (MTP) applies: ☒ No or ☐ Yes (add contractual language below). Effective Date: Enter date.

An exclusion will apply to expenses involving the replacement of teeth that were missing prior to the effective date of the dental contract. All other benefits

- Any participant who has been continuously covered for 24 months under a group dental care contract with BCBSTX or a combination of coverage of BCBSTX and the previous group dental care contract by the employer, which included prosthetic benefits.
- A partial or full denture or fixed bridge which includes replacement of a missing tooth which was extracted after coverage becomes effective.

Enhanced Dental Benefit - ☒ Yes (standard) ☐ No

Enhanced Benefit is a dental benefit that allows groups to provide additional dental benefits to members with specific medical conditions such as Cardiovascular disease, Diabetes or Pregnancy. The group must also have their medical coverage through BCBS.

Benefit for one of the following:

- Scaling & Root Planing
- Periodontal Maintenance
- One Additional 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.

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

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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 [xx] months before being eligible for the following Covered Services:

- ☐ Oral surgery
- ☐ Endontics
- ☐ 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
• **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** • **You are not required to file claim forms** • **You are not balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists**	• **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** • **You are required to file claim forms)** • **You are balance billed for costs exceeding the BCBSTX Allowable Amount** • **Non-contracting provider reimbursement U&C 90th**

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.

Enter Name
Group Executive Name and Title
(Please type or print)

_____
Signature

_ Enter date. _
Date

Enter Name
Agent of Record Name
(Please print or type)

_____
Signature

_ Enter date.
Date

Enter Name
BCBSTX Representative Name
(Please print or type)

_____
Signature

_ Enter date. _
Date