BlueCare® Dental

PPO – SILVER PLAN

BlueCross BlueShield of Texas

BRYAN ISD

Effective: 1/1/2023 - 12/31/2023

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

Program Basics	Contracting Provider	Non-Contracting Provider* U&C 90th
Benefit Period Maximum: ***Calendar Year***	$750	$750
Deductible: ***Calendar Year***	$25 Individual $75 Family	$25 Individual $75 Family
Three Month Deductible Carryover Applies	Yes ☒ No☐	Yes ☒ No☐
Prior Carrier Deductible Credit Applies	Yes ☐ No☒	Yes ☐ No☒
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 applies)*** Sealants Space maintainers	80%	80%
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	Not Covered	Not Covered
Adjunctive Services		

BlueCare® Dental

PPO – SILVER PLAN

BlueCross BlueShield of Texas

Palliative treatment (emergency) Deep sedation / general anesthesia	80%	80%
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	Not Covered	Not Covered
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 (Bony impactions typically covered under medical plan)	Not Covered	Not Covered
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	Not Covered	Not Covered
Major Restorative Services Single crown restorations Inlay/onlay restorations Labial veneer restorations Crowns placed over implants	Not Covered	Not Covered
Prosthodontic Services Complete and removable partial dentures Denture reline/rebase procedures Fixed bridgework Prosthetics placed over implants Implants Yes ☐ No☒	Not Covered	Not Covered
Miscellaneous Restorative and Prosthodontic Services Prefabricated crowns Recementations Post and core, pin retention and crown/bridge repairs Adjustments	Not Covered	Not Covered
Orthodontics Orthodontic Diagnostic Procedures and Treatment:	Not Covered	Not Covered

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

BlueCare® Dental

PPO – SILVER PLAN

BlueCross BlueShield of Texas

☒ 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.

Adjunctive Services

1. Consultations

☐ **BlueMax Advantage – Available only for 151+**

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

BlueCare® Dental

PPO – SILVER PLAN

BlueCross BlueShield of Texas

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
- ☐ 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
• **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.

BlueCare® Dental

PPO – SILVER PLAN

BlueCross BlueShield of Texas

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