BlueCare® Dental

BA0008 - PPO - Low Plan

BlueCross BlueShield of Texas

Texas Operators Association

Effective: 1/1/2022 - 12/31/2022

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* MAC
Benefit Period Maximum: Calendar Year	$1,000.00	$1,000.00
Deductible: Calendar Year	$50.00 Individual $150.00 Family	$50.00 Individual $150.00 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 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%

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Adjunctive Services		
Palliative treatment (emergency)	80%	80%
Deep sedation / general anesthesia		
Endodontic Services		
Therapeutic pulpotomy and pulpal debridement	80%	80%
Root canal therapy		
Apexification/recalcification		
Oral Surgery Services		
Surgical tooth extractions	80%	80%
Alveoloplasty and vestibuloplasty		
Excision of benign odontogenic tumor/cyst		
Excision of bone tissue		
Incision and drainage of an intraoral abscess		
Surgical Periodontal Services		
Gingivectomy or gingivoplasty and gingival flap procedures		
Clinical crown lengthening		
Osseous surgery	80%	80%
Osseous grafts		
Soft tissue grafts/allografts		
Distal or proximal wedge procedure		
Major Restorative Services		
Single crown restorations		
Inlay/onlay restorations	Not Covered	Not Covered
Labial veneer restorations		
Crowns placed over implants		
Prosthodontic Services		
Complete and removable partial dentures		
Denture reline/rebase procedures		
Fixed bridgework	Not Covered	Not Covered
Prosthetics placed over implants		
Implants Yes ☐ No ☑		
Misc. Restorative & Prosthodontic Services		
Prefabricated crowns		
Recementations	Not Covered	Not Covered
Post and core, pin retention and crown/bridge repairs		
Adjustments		
Orthodontics (Deductible Not Waived)		
Orthodontic Diagnostic Procedures and Treatment:	Not Covered	Not Covered

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Insured: Coordination of Benefits

☑ Birthday rule applies

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

☐ 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+**

Transfer-in (Takeover Credit): ☐ Yes ☑ No : $ *enter amount* **and services being Transferred-In**

Missing Tooth Provision: ☐ Yes ☑ No (add contractual language below)

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 ☐ No

Enhanced Benefit is a dental benefit that allows groups to provide additional dental benefits to member 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 Planning
- Periodontal Maintenance
- One Additional Cleaning

Apply toward annual maximum ☑ Applies ☐ 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.

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Available with 1/1/2020 effective dates:

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 requested)

NOTE: If a benefit waiting period applies; Waiting period is waived for existing group dental plans and/or transfers group.

Members must be continuously covered under this policy for [xx] 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

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*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 the Maximum Allowable In-Network Amount as payment 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 MAC

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.
  - 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.

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Group Executive Name and Title (Please type or print)	Signature	Date
Agent of Record Name (Please type or print)	Signature	Date
BCBSTX Representative Name (Please type or print)	Signature	Date

Plan I – Four Rate Structure

Employee Only	$33.39
Employee + Child(ren)	$75.14
Employee + Spouse	$66.79
Employee + Family	$108.53