BlueCare Dental℠
PPO High Plan

BlueCross BlueShield of Texas

Grand Prairie ISD

Effective: 9/1/2024

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 contracted or non-contracted provider. Your plan allows you to see any licensed dentist, but using an in-network provider may minimize your out-of-pocket expenses.

This information only provides highlights of this program. Please refer to the BlueCare Dental Certificate for additional detailed benefit information.

Summary of Dental Benefits

PROGRAM BASICS	In-Network Dentist	Out-of-Network Dentist UCR 90th
Benefit Period Maximum: Calendar Year	$2,250	$2,250
Deductible: Calendar Year	$25 Individual $0 Family	$25 Individual $0 Family
Three Month Deductible Carryover Applies	☒ Yes ☐ No	☒ Yes ☐ No
Prior Carrier Deductible Credit Applies	☒ Yes ☐ No	☒ Yes ☐ No
COVERED SERVICES		
Class 1: Preventive Services ***(Deductible does not apply)*** Periodic Oral Evaluations Problem Focused Oral Evaluations Comprehensive Oral Evaluations Prophylaxis/routine cleanings X-rays Full-Mouth, Pano, Bitewing, Periapical Sealants Topical Fluoride Space maintainers Palliative Treatment (emergency care to relieve pain)	100%	100%
Class 2: Basic Restorative Services Amalgam & Composite Fillings Non-surgical Extractions Perio Maintenance Full Mouth Debridement Scaling & Root Planning Endodontics (root canal) Periodontics Oral Surgery & Surgical Extractions Recementations	80%	80%
Class 3: Major Restorative Services Bridges & Dentures Denture Reline/Rebase Repairs – Crown & Bridge Implants: Yes ☒ No ☐ Crowns, Inlays, Onlays Deep Sedation/General Anesthesia	50%	50%
Class 4: Orthodontics Orthodontic Diagnostic Procedures & Treatment Coverage for Adults (Employee/Spouse) Coverage for Dependent Children (to age 26) Lifetime Maximum Ortho Benefit per Participant	50% **$2,000**	50% **$2,000**

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Benefit Limitations & Frequencies:	
Oral Evaluations	2 per year
X-rays: Bitewings	1 per year
X-rays Full mouth panoramic	1 per 36 months
Prophy/Cleanings	2 per year
Fluoride Application	1 per year for children up to age 16
Sealants (per tooth)	1 per 36 months up to age 16
Space Maintainers	1 per lifetime up to age 16
Amalgam & Composite Fillings	1 per tooth per 12 months
Crowns/Dentures/Bridges/Implants	Replacement every 8 years
Perio Maintenance	2 per year

Additional Features:

Missing Tooth Exclusion	☒ No Exclusion	☐ Yes Applies, XX Months
Benefit Waiting Period	☒ No Waiting Period	☐ Yes Applies
Enhanced Dental Benefit	☐ Not Included	☒ Yes, included
Graduated Annual Maximum	☒ Not Included	☐ Yes, included

Predetermination of benefits is recommended, but not required, for services in excess of $300.

This summary is intended to highlight the most common services and frequencies under the dental plan. For complete and detailed descriptions of services, limitations, and exclusions, please refer to the certificate of coverage.