BlueCare® Dental

PPO- High Plan

BlueCross BlueShield of Texas

At Homes Stores LLC

Effective:1/1/2025-12/31/2025

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***	$1750.00	$1750.00
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 ***Choose an item.*** Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	100%	100%
Preventive Services ***Choose an item.*** Prophylaxis (cleanings) Topical fluoride applications	100%	100%
Diagnostic Radiographs ***Choose an item.*** Full-mouth and panoramic films Bitewing films Periapical films	100%	100%
Miscellaneous Preventive Services ***Choose an item.*** 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	50%	50%

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Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia	50%	50%
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	50%	50%
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)	50%	50%
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	50%	50%
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 **Choose an item.** Orthodontic Diagnostic Procedures and Treatment: Adults eligible: ☒ No ☐ Yes Dependent Children eligible: ☒ No ☐ Yes If yes age limitation: 19 Standard **Lifetime Maximum Benefit per Participant**	50% $1000.00	50% $1000.00

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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:
Pano and full mouth x-rays 1 in 36 months, Fluoride to age 14, Space Maintainer to age 16, Sealants 1 in 36 months to age 16, Periodontal Scaling & Root Planing 1 in 24 months, 10 year replacement on Major Restorative and Prosthodontic Appliances

☐ **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

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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
☐ 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 [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

*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**	• **Choose an item.** • **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**

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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