BlueCare® Dental

Voluntary HMO Plan 830

BlueCross BlueShield of Illinois

The following is a listing of common services available through your BlueCare Dental HMO providers. The member's share of the cost is determined when care is received from a contracting dentist.

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

BENEFIT HIGHLIGHTS

Services	Copayment (Member Pays)
Diagnostic & Preventive	
Periodic oral evaluations	*$0*
Bitewing x-rays	*$0*
Prophylaxis – adult & child cleaning	*$0*
Fluoride treatment	*$0*
Miscellaneous	
Pulp vitality tests	*$0*
Sealant application – per tooth	*$0*
Space maintainer – fixed – unilateral	*$70*
Emergency care (treatment for the relief of pain)	*$20*
Restorative **(includes postoperative evaluation and local anesthetic)**	
Amalgam – one surface	*$25*
Resin-based composite – one surface anterior	*$35*
Resin-based composite three surfaces anterior	*$50*
Pin retention (per tooth) – in addition to restoration	*$10*
Extraction erupted tooth or exposed root	*$85*
General	
Prefabricated stainless steel crown – primary	*$55*
Deep sedation / general anesthesia – first 30 minutes	*$140*
Occlusal adjustment - limited	*$25*
Endodontics **(includes postoperative evaluation and local anesthetic)**	
Pulp cap – direct	*$40*
Root canal – anterior	*$250*
Root canal – bicuspid	*$400*
Root canal – molar	*$500*
Apicoectomy – bicuspid	*$290*

Services	Copayment (Member Pays)
Periodontics **(includes postoperative evaluation and local anesthetic)**	
Gingivectomy or gingivoplasty – per quadrant(1-3 teeth)	*$80*
Osseous surgery, flap entry and closure – per quadrant (1-3 teeth)	*$210*
Scaling and root planing – per quadrant (1-3 teeth)	*$65*
Periodontal maintenance	*$45*
Oral Surgery **(includes postoperative evaluation and local anesthetic)**	
Surgical removal of tooth – soft tissue impaction	*$115*
Surgical removal of tooth – partial bony impaction	*$155*
Alveoloplasty – without extractions – per quadrant (1-3 teeth)	*$185*
Crowns, Inlays / Onlays	
Inlay – porcelain / ceramic – one surface	*$445*
Onlay – porcelain / ceramic – two surfaces	*$485*
Crown – porcelain fused to noble metal	*$410*
Crown – ¾ porcelain / ceramic	*$410*
Crown – full cast noble metal	*$410*
Prosthodontic	
Complete denture – maxillary	*$625*
Mandibular partial denture – resin base	*$675*
Pontic – porcelain fused to noble metal	*$505*
Inlay – porcelain / ceramic two surfaces (bridge retainer)	*$390*
Onlay – porcelain / ceramic two surfaces (bridge retainer)	*$425*
Crown – porcelain fused to noble metal (bridge retainer)	*$510*
Crown ¾ porcelain / ceramic (bridge retainer)	*$515*
Orthodontics	
Includes consultations, records fee, treatment and retention. Coverage is limited to one course of Phase II treatment. Total coverage period for treatment and retention will be for a maximum of 24 months.	
• Member	*$4,600*
• Spouse	*$4,600*
• Eligible child to age 19	*$4,600*

Program Basics

Out-Of-Area Emergency Care

Emergency treatment refers only to those dental services to alleviate pain and suffering. Emergency care received from a dental provider other than the primary care dentist will be reimbursed up to a maximum amount of **$50**

Accidental Injury

There is no coverage for accidental injury, which is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages resulting from normal chewing function will be covered at the schedule of benefits based on the plan.

Age Limitations

Dependent children are covered to age **26**. Eligible military personnel covered to age **30**.

Maximum Annual Benefit

None

BlueCare® Dental

Choice PPO

BlueCross BlueShield of Illinois

Cicero SD #99

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.

BENEFIT HIGHLIGHTS

Program Basics	Contracting Provider*	Non-Contracting Provider**
Benefit Period Maximum	*$1,000 per benefit period*	*$1,000 per benefit period*
Deductible	*$50 per person per benefit period* *$150 maximum per family*	*$75 per person per benefit period* *$225 maximum per family*
Dependent Coverage	*Spouse and unmarried dependent up to age 26*	

Services		
Diagnostic & Preventive Services		
Dental exams Cleanings X-rays Fluoride treatment	*100% of Maximum Allowance*	*80%of Usual and Customary*
Miscellaneous Services		
Sealants Space maintainers Labs & tests	*80% of Maximum Allowance*	*80%of Usual and Customary*
Emergency Care Treatment for the relief of pain	*80% of Maximum Allowance*	*80%of Usual and Customary*
Restorative Services		
Routine fillings (amalgams and resins) Pin retention Simple extractions	*80% of Maximum Allowance* *After deductible*	*80% of Usual and Customary* *After deductible*
General Services		
Intravenous sedation General anesthesia Stainless steel crowns	*80% of Maximum Allowance* *After deductible*	*80% of Usual and Customary* *After deductible*
Endodontic Services		
Root canals Pulp caps Apicoectomy / apexification	*50% of Maximum Allowance* *After deductible*	*50% of Usual and Customary* *After deductible*
Periodontic Services		
Scaling & root planing Gingivectomy / gingivoplasty Osseous surgery	*50% of Maximum Allowance* *After deductible*	*50% of Usual and Customary* *After deductible*
Oral Surgery Services		
Surgical extractions Alveoloplasty Vestibuloplasty	*50% of Maximum Allowance* *After deductible*	*50% of Usual and Customary* *After deductible*
Crowns, Inlays / Onlays Services		
Crowns Inlays / onlays Prefabricated posts and cores Repair and recementation of crown, inlays / onlays	*50% of Maximum Allowance* *After deductible*	*50% of Usual and Customary* *After deductible*
Prosthodontic Services		
Bridges and dentures Reline / rebase of dentures Addition of tooth or clasp Repair of bridges and dentures	*50% of Maximum Allowance* *After deductible*	*50% of Usual and Customary* *After deductible*
Orthodontics	*50% coverage for children to age 19* *$1,000 Lifetime Maximum*	*50% coverage for children to age 19* *$1,000 Lifetime Maximum*

* Schedule of Maximum Allowances
Contracting Providers have agreed to accept the Schedule of Maximum Allowances as payment in full for covered services. **Services from Non-Contracting Providers will be subject to usual and customary allowances as determined by the Company. Amounts in excess of these allowances will be the full responsibility of the insured.

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