

# Understanding your benefits

## Standard Provisions

### Deductibles

You pay the following amounts each year before your health plan starts to pay toward the cost of covered services:

- \$25 deductible per individual (dependents under age 19)

### In Network Calendar Year Maximum

The following is the calendar year maximum the dental plan would pay each year:

For Dependents Under Age 19:

- No maximum

For Dependents Age 19 & Over:

- \$1,500 - per member

### In Network Out-of-pocket Limits

The following is the maximum you would pay out of pocket each year:

For Dependents Under Age 19:

- \$350 for individual plan
- \$700 per family plan

| Service                   | Plan Pays            |                 | Description                                                                                                                                                                                                                                                                                                                                          |
|---------------------------|----------------------|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                           | Up to age 19         | Age 19 and over |                                                                                                                                                                                                                                                                                                                                                      |
| Diagnostic and Preventive |                      |                 |                                                                                                                                                                                                                                                                                                                                                      |
| Oral Evaluations          | 100%                 | 100%            | <b>Under age 19:</b> Two routine or emergency oral examinations performed by a general dentist per calendar year.<br><b>Age 19 &amp; over:</b> One routine or emergency oral examination performed by a general dentist per calendar year.                                                                                                           |
| Cleanings                 | 100%                 | 100%            | <b>Under age 19:</b> Three cleanings per calendar year.<br><b>Age 19 &amp; over:</b> Two cleanings per calendar year.                                                                                                                                                                                                                                |
| Fluoride Treatment        | 100%                 | N/C             | Two fluoride treatments per calendar year for members under age 19                                                                                                                                                                                                                                                                                   |
| X-rays                    | 100%                 | 100%            | Bitewing X-rays – Two sets per calendar year for members under age 19. One set per calendar year for members age 19 and over.<br>Full Series or Panoramic X-rays – One set per 60 months<br>Individual X-rays – Four per calendar year                                                                                                               |
| Sealants                  | 100%                 | N/C             | One sealant treatment per permanent molar every 36 months for members under age 19                                                                                                                                                                                                                                                                   |
| Space Maintainers         | 100%                 | N/C             | Limited to members under the age of 14                                                                                                                                                                                                                                                                                                               |
| Palliative Treatment      | 80%                  | 100%            | Minor treatment to relieve sudden, intense pain – two per calendar year                                                                                                                                                                                                                                                                              |
| Basic Dental              |                      |                 |                                                                                                                                                                                                                                                                                                                                                      |
| Fillings                  | 50% after deductible | 80%             | Amalgam (silver fillings) – all teeth; composite (white fillings) on front teeth only. Limited to replacement 12 months after original filling is placed. For composite fillings on posterior (back) teeth, the plan pays the amalgam benefit allowance only, and the member is responsible for the difference in payment up to the dentist's charge |
| Simple Extractions        | 50% after deductible | 80%             | Removal of an erupted tooth not requiring surgery                                                                                                                                                                                                                                                                                                    |
| Denture Repairs           | 50% after deductible | 50%             | Rebasing and relining covered once every 36 months                                                                                                                                                                                                                                                                                                   |

## Out-of-Network Coverage

When you visit out-of-network dentists you are still covered. Payment to the provider will be based on your plan's reimbursement allowance, less any applicable coinsurance and/or deductible. Please refer to the Blue Cross Dental Subscriber Agreement for specific details.

## Total Health Solutions

Your oral health can impact your overall health. Total Health Solutions provides enhanced dental benefits for members with certain health conditions, including:

- Non-surgical periodontal and periodontal maintenance – coinsurance is waived for these services for members who have been diagnosed with diabetes and/or coronary heart disease.
- Cleanings (prophylaxis) – members who are pregnant qualify for one additional cleaning (above the two provided per plan year) during their pregnancy.

Please refer to your Blue Cross Dental Subscriber Agreement for more information.

## Beyond Benefits

Your **myBCBSRI** account gives you quick, convenient access to plan and wellness information.

Manage your plan:

- Get a list of your benefits and recent claims
- See how much you've paid toward your deductible
- Use our online Find a Doctor tool to find a qualified dentist of your choice

Visit [myBCBSRI.com](https://myBCBSRI.com) to register your account today.

| Service                                                              | Plan Pays            |                 | Description                                                                                                                                                                                                    |
|----------------------------------------------------------------------|----------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                      | Up to age 19         | Age 19 and over |                                                                                                                                                                                                                |
| <b>Root Canal Therapy (Anterior Teeth)*</b>                          | 50% after deductible | 50%             | Root canal services for all permanent anterior (front) teeth                                                                                                                                                   |
| <b>Root Canal Therapy (Posterior Teeth)*</b>                         | 50% after deductible | 50%             | Root canal services for all permanent posterior (back) teeth, including bicuspid and molars. Final restoration is excluded                                                                                     |
| <b>Oral Surgery*</b>                                                 | 50% after deductible | 50%             | Surgical extractions and other eligible oral surgery procedures, including general anesthesia for covered surgical services                                                                                    |
| <b>Non-surgical Periodontal Services*</b>                            | 50% after deductible | 50%             | Non-surgical treatment of periodontal disease, including root planing scaling, and periodontal maintenance                                                                                                     |
| <b>Surgical Periodontal Services*</b>                                | 50% after deductible | 50%             | Surgical treatment of periodontal disease, including tissue grafts, osseous surgery, and crown lengthening                                                                                                     |
| <b>Major Dental</b>                                                  |                      |                 |                                                                                                                                                                                                                |
| <b>Crowns, Inlays and Onlays*</b>                                    | 50% after deductible | 50%             | Single tooth crowns or onlays for permanent, natural teeth—not part of a fixed bridge.<br><br>Replacement limited to once every 60 months. Other major restorative services include build-ups, post, and cores |
| <b>Bridges and Dentures*</b>                                         | 50% after deductible | 50%             | Fixed bridges, partial and complete dentures; replacement limited to once every 60 months                                                                                                                      |
| <b>Single Tooth Implant*</b>                                         | 50% after deductible | 50%             | Covered in lieu of a three-unit bridge; replacement limited to once per tooth site per lifetime                                                                                                                |
| <b>Orthodontics</b>                                                  |                      |                 |                                                                                                                                                                                                                |
| <b>Braces*</b>                                                       | 50% after deductible | N/C             | Braces and related orthodontic services for members under age 19. Only medically necessary braces are covered.                                                                                                 |
| <b>Oral Appliances – Deductible does not apply to these services</b> |                      |                 |                                                                                                                                                                                                                |
| <b>Night Guards</b>                                                  | 50%                  | 50%             | Night Guards                                                                                                                                                                                                   |

\*Predetermination is recommended

Note: N/C = Not Covered

This is a summary of your dental benefits. It is not a contract. For details about your coverage, including any limitations or exclusions not noted here, please refer to your subscriber agreement or call the number located on the back of your BCBSRI ID card. If you have questions about receiving medical care, please call your doctor.