BlueCross BlueShield of Illinois

BlueCare Dental PPO℠ Voluntary

Plan ID: DINLM25

This information only provides a summary of the benefits for this Dental Plan. Please refer to your Dental Benefit Booklet for additional benefit information. The Deductibles, Coinsurance and Benefit Period Maximum shown below are subject to change as permitted by applicable law.

Summary of Dental Benefits

Program Basics	In Network	Out of Network**
Benefit Period Maximum	$1,000	
Deductible	$50 Individual/$150 Family	$50 Individual/$150 Family

Covered Services

Diagnostic Evaluations Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	100% (Deductible does not apply)	100% (Deductible does not apply)
Preventive Services Prophylaxis (cleanings) Topical fluoride applications	100% (Deductible does not apply)	100% (Deductible does not apply)
Diagnostic Radiographs Full-mouth and panoramic films Bitewing films Periapical films	100% (Deductible does not apply)	100% (Deductible does not apply)
Miscellaneous Preventive Services Sealants Space maintainers	80%	80%
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 Periodontal Services Periodontal scaling and root planing Full-mouth debridement Periodontal maintenance procedures	80%	80%
Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia	80%	80%
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	50%	50%