Small Group Standard BlueCrossDental | Blue Cross Blue Shield of Rhode Island

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:

- $150 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: ■ $1,000 - 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

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.

Service	Plan Pays		Description
	Under Age 19	Age 19 & Over	
Diagnostic and Preventive – Deductible does not apply to these services			
Oral Exams	100%	100%	**Under age 19:** Two routine or emergency oral examinations performed by a general dentist per calendar year. **Age 19 & over:** One routine or emergency oral examination performed by a general dentist per calendar year.
Cleanings	100%	100%	Two cleanings per calendar year.
Fluoride Treatment	100%	N/C	Two fluoride treatments for members under age 19, per calendar year.
X-rays	100%	100%	Bitewing X-rays – Two sets per calendar year for members up to age 19. One set per calendar year for members age 19 and older. Full Series or Panoramic X-rays – One set per 60 months. Individual X-rays – Four per calendar year.
Sealants	100%	N/C	One sealant treatment per permanent molar for members under age 19, every 36 months.
Space Maintainers	100%	N/C	Applies only to members under age 14.
Palliative Treatment	80%	60%	Minor treatment to relieve sudden, intense pain.
Basic Dental - Deductible applies to these services			
Fillings	50% after deductible	60%	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	25% after deductible	60%	Removal of an erupted tooth not requiring surgery.
Denture Repairs	25% after deductible	50%	Rebasing and relining covered once every 36 months.

continued

Beyond Benefits

When you sign in to your member page on **BCBSRI.com**, you have useful plan and wellness information at your fingertips.

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.

Need Help?

Call Customer Service

- Locally: (401) 453-4700
- Outside Rhode Island 1-800-831-2400
- TTY/TDD (Telecommunication Device for the Deaf) Users should call 711

Hours:
Monday – Friday, 8:00 a.m. to 8:00 p.m., Eastern Time

Service	Plan Pays		Description
	Under Age 19	Age 19 & Over	
Root Canal Therapy	25% after deductible	60%	Root canal services for all permanent teeth. Final restoration is excluded.
Oral Surgery*	25% after deductible	60%	Surgical extractions and other eligible oral surgery procedures, including general anesthesia for covered surgical services.
Non-surgical Periodontics*	25% after deductible	N/C	Non-surgical treatment of periodontal disease, including root planing and scaling, periodontal maintenance.
Surgical Periodontics*	25% after deductible	N/C	Surgical treatment of periodontal disease, including tissue grafts, osseous surgery, and crown lengthening.
Major Dental - Deductible applies to these services			
Crowns and Onlays*	25% after deductible	N/C	Single tooth crowns or onlays for permanent, natural teeth – not part of a fixed bridge. Replacement limited to once every 60 months. Other major restorative services include build-ups, post and cores.
Bridges and Dentures*	25% after deductible	N/C	Fixed bridges, partial and complete dentures; replacement limited to once every 60 months.
Single Tooth Implant*	25% after deductible	N/C	Covered in lieu of a three-unit bridge; replacement limited to once per tooth site per lifetime.
Orthodontics -Under age 19, deductible applies to these services			
Braces*	50% after deductible	N/C	Braces and related orthodontic services for members under age 19. Only medically necessary braces are covered.
Oral Appliances – Deductible does not apply to these services			
Night Guards	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 our Customer Service Department. If you have questions about receiving dental care, please call your dentist.

Blue Cross Blue Shield of Rhode Island
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