BlueCare Dental[SM]
PPO Plan

BlueCross BlueShield of Illinois

IBEW NECA Southwestern

Effective: 1/1/2026

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 contracted or non-contracted provider. Your plan allows you to see any licensed dentist, but using an in-network provider may minimize your out-of-pocket expenses.

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

Summary of Dental Benefits

PROGRAM BASICS	In-Network Dentist	Out-of-Network Dentist MAC
Benefit Period Maximum: Calendar Year	$1,250	$1,000
Deductible: Calendar Year	$50 Individual $100 Family	$50 Individual $100 Family
Prior Carrier Deductible Credit Applies	☐ Yes ☒ No	☐ Yes ☒ No
COVERED SERVICES		
Class 1: Preventive Services ***(Deductible does not apply)*** Periodic Oral Evaluations Problem Focused Oral Evaluations Comprehensive Oral Evaluations Prophylaxis/routine cleanings X-rays Full-Mouth, Pano, Bitewing, Periapical Sealants Topical Fluoride Space maintainers	100%	100%
Class 2: Basic Restorative Services Amalgam & Composite Fillings Non-surgical Extractions Perio Maintenance Full Mouth Debridement Scaling & Root Planning Palliative Treatment (emergency care to relieve pain) Oral Surgery & Surgical Extractions Wisdom Teeth Removal Endodontics (root canal) Major Periodontics Deep Sedation/General Anesthesia	80%	60%
Class 3: Major Restorative Services Bridges & Dentures Implants: Yes ☐ No ☒ Crowns, Inlays, Onlays Denture Reline/Rebase Repairs – Crown & Bridge	50%	40%
Class 4: Orthodontics (Not Covered) Orthodontic Diagnostic Procedures & Treatment Coverage **Lifetime Maximum Ortho Benefit per Participant**	**N/A**	**N/A**

BlueCare Dental℠

PPO Plan

BlueCross BlueShield of Illinois

Benefit Limitations & Frequencies:	
Oral Evaluations	2 per year
Comprehensive Evaluations	1 per 3 years
X-rays: Bitewings	1 per year
X-rays Full mouth panoramic	1 per 5 years
Prophy/Cleanings	2 per year
Fluoride Application	2 per year for children up to age 19
Sealants (per tooth)	1 per lifetime up to age 19
Space Maintainers	1 per lifetime up to age 14
Amalgam & Composite Fillings	1 per tooth per 2 years
Crowns/Dentures/Bridges	Replacement every 5 years
Denture Reline/Rebase	1 per 2 years
Perio Maintenance	2 per year
Wisdom Teeth Removal	Covered on this dental plan. Not covered under medical.

Included Plan Features:

Missing Tooth Exclusion: This plan covers replacement of tooth/teeth missing prior to your effective date under this policy.

No Benefit Waiting Period: There is no required period of time a member must be covered under the plan before receiving coverage for dental procedures.

Enhanced Dental Benefit: Participants diagnosed and receiving active medical care for cardiovascular disease, diabetes, prediabetes or pregnancy qualify for one of the following enhanced dental benefits after standard benefits are exhausted: one additional cleaning, periodontal scaling and root planing or periodontal maintenance. Enhanced benefit services will apply toward your individual annual maximum.

Finding a Provider: For a list of in-network general and specialty dentists, go to **bcbsil.com** and click on ***Find Care*** and then on ***Find a Dentist*** on the left side of the page. You can search for a dentist near your home, school or office.

QR Code to Provider Finder site

Predetermination of benefits is recommended, but not required, for services in excess of $300.

This summary is intended to highlight the most common services and frequencies under the dental plan. For complete and detailed descriptions of services, limitations, and exclusions, please refer to the certificate of coverage.