BlueCross BlueShield of Illinois

Pediatric Dental Benefit for IL PPO Medical Plans

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

Note: PPO plans where the Deductible is equal to the OPX, Pediatric Dental coverage is 100% after the Deductible is met.

Summary of Dental Benefits

Program Basics	In Network	Out of Network**
Medical Deductible/OPX	Dental Benefits subject to **INN** Medical Deductible/OPX	Dental Benefits subject to **OON** Medical Deductible/OPX
Covered Services		
Diagnostic Evaluations Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	70%	50%
Preventive Services Prophylaxis (cleanings) Topical fluoride applications (Fluoride treatment covered at 100% - deductible waived)	70%	50%
Diagnostic Radiographs Full-mouth and panoramic films Bitewing films Periapical films	70%	50%
Miscellaneous Preventive Services Sealants Space maintainers	70%	50%
Basic Restorative Dental Services Amalgams Resin-based composite restorations	70%	50%
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	70%	50%
Non-Surgical Periodontal Services Periodontal scaling and root planing Full-mouth debridement Periodontal maintenance procedures	70%	50%
Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia	70%	50%
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	70%	50%

	In Network	Out of Network**
Covered Services (continued)		
Oral Surgery Services Surgical tooth extractions Alveoloplasty and vestibuloplasty Excision of benign odontogenic tumor/cyst Excision of bone tissue Incision and drainage of an intraoral abscess	70%	50%
Surgical Periodontal Services Gingivectomy or gingivoplasty and gingival flap procedures Clinical crown lengthening Osseous surgery Osseous grafts Soft tissue grafts/allografts Distal or proximal wedge procedure Anatomical crown exposures	70%	50%
Major Restorative Services Single crown restorations Gold foil and inlay/onlay restorations Labial veneer restorations Crowns placed over implants	70%	50%
Prosthodontic Services Complete and removable partial dentures Denture reline/rebase procedures Fixed bridgework Prosthetics placed over implants	70%	50%
Miscellaneous Restorative and Prosthodontic Services Prefabricated crowns Recementations Post and core, pin retention and crown/bridge repairs Adjustments	70%	50%
Orthodontic Services		
Pediatric Orthodontic Services: Coverage limited to an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)	70%	50%

Dental implants are not covered.

The above is a listing of common services available through your network of Participating Dentists.
The Member's share of the cost is determined by whether care is received from a Participating or Non-Participating Dentist.

****For services rendered by a Non-Participating Dentist (out of network), the Allowable Charge is the Provider's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist rendering the same services. The Member will be responsible for the full amount by which the Non-Participating Dentist's actual charges exceed the Allowable Charge.**