BlueCare Dental[SM]
PPO Plan

BlueCross BlueShield of New Mexico

City of Albuquerque

Effective: 7/1/2024

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: Plan Year	$1,500	$1,500
Deductible: Plan Year	$50 Individual $150 Family	$50 Individual $150 Family
Three Month Deductible Carryover Applies	☒ Yes ☐ No	☒ Yes ☐ No
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 Perio Peridontal Maintenance Full Mouth Debridement Palliative Treatment (emergency care to relieve pain)	100%	80%
Class 2: Basic Restorative Services Amalgam & Composite Fillings Non-surgical Extractions Scaling & Root Planning Denture Reline/Rebase Repairs – Crown & Bridge Oral Surgery & Surgical Extractions Endodontics (root canal) Major Periodontics	85%	85%
Class 3: Major Restorative Services Bridges & Dentures Implants: Yes ☒ No ☐ Crowns, Inlays, Onlays Deep Sedation/General Anesthesia Diagnostic imaging and appliances for the diagnosis and/or treatment of TMJ (Temporomandibular joint dysfunction)	50%	50%
Class 4: Orthodontics Orthodontic Diagnostic Procedures & Treatment Coverage for Adults & Dependent Children (to age 26) **Lifetime Maximum Ortho Benefit per Participant**	50% **$1,200**	50% **$1,200**

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Benefit Limitations & Frequencies:	
Oral Evaluations	2 per year
Comprehensive Evaluations	2 per 12 months
X-rays: Bitewings	2 per year
X-rays Full mouth panoramic	1 per 60 months
Prophy/Cleanings	2 per year
Fluoride Application	2 per year for children up to age 19
Sealants (per tooth)	1 per 24 months up to age 16
Space Maintainers	1 per lifetime up to age 14
Amalgam & Composite Fillings	1 per tooth per 24 months
Crowns/Dentures/Bridges/Implants	Replacement every 5 years
Denture Reline/Rebase	1 per 36 months
Periodontal Maintenance	2 per year

Additional Features:

Class 1 Preventive Services	☒ Will Not apply to your Annual Maximum Benefit	☐ Will apply to your Annual Maximum Benefit
Missing Tooth Exclusion	☒ No Exclusion	☐ Yes Applies
Benefit Waiting Period	☒ No Waiting Period	☐ Yes Applies
Enhanced Dental Benefit	☐ Not Included	☒ Yes, included
Graduated Annual Maximum	☒ Not Included	☐ Yes, included

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.

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