FlexChoice Certified 304C

Understanding Your Benefits

Standard Provisions

$1,500 - annual maximum per member age 19 and over

$50 deductible per individual plan

$150 deductible per family plan

Dependents covered until age 26

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 19	Age 19 and over	
Diagnostic and Preventive			
Oral Exams	100%	100%	Up to age 19 - Two routine or emergency oral examinations performed by a general dentist per calendar year. 19 and 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%	Not covered	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 under the age of 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%	Not covered	One sealant treatment per permanent molar for members under age 19, every 36 months.
Space Maintainers	100%	Not covered	Limited to members under age 14.
Palliative Treatment	100%	100%	Minor treatment to relieve sudden, intense pain. Two per calendar year.
Basic Dental			
Fillings	80% after deductible	80% after deductible	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	80% after deductible	80% after deductible	Removal of an erupted tooth not requiring surgery.

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 19	Age 19 and over	
Denture Repairs	80% after deductible	80% after deductible	Rebasing and relining covered once every 36 months.
Root Canal Therapy (Anterior Teeth)	80% after deductible	80% after deductible	Root canal services for all permanent anterior (front) teeth.
Root Canal Therapy (Posterior Teeth)	80% after deductible	80% after deductible	Root canal services for all permanent posterior (back) teeth, including bicuspids and molars. Final restoration is excluded.
Oral Surgery*	80% after deductible	80% after deductible	Surgical extractions and other eligible oral surgery procedures, including general anesthesia for covered surgical services.
Non-surgical Periodontics*	80% after deductible	80% after deductible	Non-surgical treatment of periodontal disease, including root planning and scaling, periodontal maintenance.
Surgical Periodontics*	80% after deductible	50% after deductible	Surgical treatment of periodontal disease, including tissue grafts, osseous surgery, and crown lengthening.
Major Dental			
Crowns, Inlays and Onlays*	50% after deductible	50% after deductible	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*	50% after deductible	50% after deductible	Fixed bridges, partial and complete dentures; replacement limited to once every 60 months.
Single Tooth Implant*	50% after deductible	50% after deductible	Covered in lieu of a three-unit bridge; replacement limited to once per tooth site per lifetime.
Orthodontics			
Braces (Medically Necessary)	50%	Not covered	Braces and related orthodontic services for members under age 19. Only medically necessary braces are covered.
Braces (Elective)*	Not covered	Not covered	Braces and related orthodontic services for members under age 19. Limited to the orthodontic lifetime maximum.
Lifetime Maximum	N/A	N/A	Orthodontic services lifetime maximum per member.

*Predetermination is recommended

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
www.bcbsri.com
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