BlueCare Dental[SM]
NMRHCA- PPO Comprehensive Plan

BlueCross BlueShield of New Mexico

IBAC-New Mexico Retiree Health Care Authority

Effective: 7/1/2024 - 6/30/2028

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 UCR 80th
Benefit Period Maximum: Calendar Year	$1,500	$1,000
Deductible: Calendar 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 Palliative Treatment (emergency care to relieve pain)	100%	75%
Class 2: Basic Restorative Services Amalgam & Composite Fillings Non-surgical Extractions Perio Maintenance Full Mouth Debridement Scaling & Root Planning Denture Reline/Rebase Repairs – Crown & Bridge Oral Surgery & Surgical Extractions Endodontics (root canal) Major Periodontics Deep Sedation/General Anesthesia	80%	55%
Class 3: Major Restorative Services Bridges & Dentures Implants: Yes ☒ No ☐ Crowns, Inlays, Onlays	50%	35%

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Class 4: Orthodontics Orthodontic Diagnostic Procedures & Treatment Coverage for Adults & Dependent Children (to age 26)	50%	50%
Lifetime Maximum Ortho Benefit per Participant	**$1,000**	**$500**

Benefit Limitations & Frequencies:	
Oral Evaluations	2 per year
Comprehensive Evaluations	1 per 36 months
X-rays: Bitewings	2 per year
X-rays Full mouth panoramic	1 per 60 months
Prophy/Cleanings	3 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 19
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	4 per year (combined with Prophy/cleanings)

Additional Features:

Missing Tooth Exclusion	☒ No Exclusion	☐ Yes
Benefit Waiting Period	☒ No Waiting Period	☐ Yes
Enhanced Dental Benefit	☐ Not Included	☒ Yes, included
Graduated Annual Maximum	☒ Not Included	☐ Yes

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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