BlueCare Dental℠

PPO Enhanced Plan

BlueCross BlueShield of Illinois

Team TAG Services, LLC

Effective: 1/1/2026

The following is a listing of common services available through your BlueCare Dental PPO℠ plan. 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 and prevent you from being subject to balance billing.

For information regarding exclusive dental discounts offered by your employer, please visit mytagbenefits.com

Summary of Dental Benefits

PROGRAM BASICS	In-Network Dentist	Out-of-Network Dentist
Benefit Period Maximum: Calendar Year	$2,000	$2,000
Deductible: Calendar Year	$25 Individual $75 Family	$25 Individual $75 Family
Reimbursement Level:	Contracted Fee Schedule	UCR 80th
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	100%	100%
Class 2: Basic Restorative Services Topical Fluoride Sealants Space Maintainers Amalgam (silver) and Composite (tooth colored) Fillings Scaling and Root Planing Periodontal Maintenance Palliative Treatment (emergency care to relieve pain) Endodontics (Root Canal)	80%	80%
Class 3: Major Restorative Services Deep Sedation/General Anesthesia Non-Surgical Extractions Oral Surgery and Surgical Extractions Major Periodontics Repairs – Crown and Bridge Crowns, Inlays, Onlays Denture Reline/Rebase Bridges and Dentures Implants	50%	50%
Class 4: Orthodontics ***(Deductible does not apply)*** Orthodontic Diagnostic Procedures and Treatment Coverage for Adults and Dependent Children (to age 26) **Lifetime Maximum Ortho Benefit per Participant**	50% **$2,000**	50% **$2,000**

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Benefit Limitations & Frequencies:	
Oral Evaluations	2 per year
Prophy/Cleanings	2 per year
Fluoride Application	1 per year for children up to age 14
X-rays Full Mouth Panoramic	1 per 60 months
X-rays: Bitewings	1 per year
Sealants (per tooth)	1 per lifetime up to age 14
Space Maintainers (per tooth)	1 per lifetime up to age 14
Amalgam and Composite Fillings	1 per tooth per 24 months
Periodontal Maintenance	2 per year
Crowns/Dentures/Bridges/Implants	Replacement every 10 years
Denture Reline/Rebase (if at least 6 months after installation)	1 per 36 months

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.

Three-Month Deductible Carryover: Any covered dental expenses incurred **in the final three months of the plan year** and applied toward satisfaction of the deductible for that plan year will also be applied toward satisfaction of the deductible for the following plan year.

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.

Please note that your benefit plan reimburses services rendered by non-contracted dentists up to the 80th percentile of all usual, customary, and reasonable (UCR) submitted charges in that same geographic area. If your dentist's bill is higher than what the plan allows, you may be responsible for the difference.

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.