BlueDental Choice
Benefit Summary

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

Group Name: ARC DIALYSIS LLC

Group Effective Date: 10/01/2025

Deductible No Deductible for Preventive Services (or ortho if selected) Per Person Per Plan Year Per Family Per Plan Year	**In-Network** $50 $150	**Out-of-Network** $50 $150
Amounts used to satisfy the in-network deductible also satisfy the out-of-network deductible and amounts used to satisfy the out-of-network deductible also satisfy the in-network deductible.		

	In-Network		Out-of-Network	
	We Pay*	You Pay*	We Pay*	You Pay**
Preventive Services	100%	0%	100%	0%
Basic Services	80%	20%	80%	20%
Major Services	50%	50%	50%	50%
Periodic Oral Evaluation (0120)	Preventive			
Comprehensive Oral Evaluation (0150)	Preventive			
Bitewing X-rays, two films (0272)	Preventive			
Cleanings – Adult/Child (1110, 1120)	Preventive			
Fluoride Treatment – Child (1206,1208)	Preventive			
Office Visits (9430)	Preventive			
Space Maintainers – fixed – unilateral (1510)	Preventive			
X-rays - Intraoral/Complete Series (0210)	Preventive			
Sealant – per tooth (1351)	Preventive			
Amalgam Restorations (Silver Fillings) (2140)	Basic			
Resin-Based Restorations – Anterior (2330)	Basic			
Extractions – Routine and Surgical (7140)	Basic			
Root Canal Molar (3330)	Major			
Periodontal Scaling & Root Planing – per quad (4341)	Major			
Osseous Surgery – 4 or more contiguous teeth (4260)	Major			
Crowns – Porcelain fused to noble metal (2752)	Major			
Complete Dentures (5110, 5120)	Major			
Pontic – Porcelain fused to noble metal (6242)	Major			
Partial Dentures (5213, 5214)	Major			
Surgical placement of implant body – endosteal implant (6010)	Major			
Implant supported porcelain fused to metal crown (titanium, high noble metal) (6066)	Major			
Orthodontia Services BlueDental Coverage	All Insureds 50% / 50%			
Maximum Benefits Plan Year (per person) Lifetime Orthodontia (per person)	 $1500 / $1500 $1000 / $1000			
The amount of benefits payable is limited to the in-network maximums. In-network maximums apply toward the out-of-network maximums and out-of-network maximums apply to the in-network maximums.				
Dental Rollover	Opt In			

The information provided above is a summary of benefits. It is intended to highlight key points of the Dental Plan and is provided to the employee as an aid in deciding whether to enroll in the Plan. This summary should in no way be construed as part of the contract. Possession of this summary in no way implies coverage nor does it guarantee benefits under the plan.

Some limitations may apply.

*Percentage of allowable charge.
**Percentage allowable charge, plus balance of charges, if any.

Note: Non-Participating Dentists may charge fees in excess of our Fee Schedule and may bill you for the difference.

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Limitations and Exclusions

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Limitations

- Any retreatment of root canals are payable one (1) year after completion date of root canal therapy.
- Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
- The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
- Sealants are limited to the first and second molars for primary teeth and the bicuspids and molars for the permanent teeth of dependent children.
- General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.
- Periodontal services are limited to insureds age eighteen (18) and older.
- Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.
- Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.
- All fixed prosthetics are billable upon the seat/insertion date.
- All removable prosthetics are billable upon final delivery

Exclusions

The following are excluded under this plan:

- Services or supplies which are not medically necessary according to accepted standards of dental practice, as determined by our consulting dentists, or which are not recommended or approved by the attending dentist.
- Charges for services or supplies when billed by other than a dentist.
- Benefits for services rendered by a member of an employee's family, (his spouse and the children, brothers, sisters and parents of either the employee or his spouse).
- Services rendered primarily for cosmetic purposes.
- Charges incurred for failure to keep a dental appointment.
- Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
- Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone—lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
- Experimental or investigational treatment.
- Dental services received or rendered:
  - through or in a veteran's hospital or government facility due to a service connected disability
  - which are covered and paid under Worker's Compensation or similar law
  - which are coordinated with another insurance policy providing dental benefits for the same charges, to the extent that the total amount payable under both plans exceeds 100% of the total expenses that are incurred
- Services for which the insured incurs no charge.
- Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.
- Local anesthesia when billed separately by a dentist.
- Any services paid or payable under the insured's health insurance contract.
- Services not listed in the Benefits section of this plan.
- Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this certificate will be based on the allowance for the least costly service, procedure, or course of treatment.
- Any additional treatment required due to the insured's failure to follow instructions, or lack of cooperation with the dentist.
- Treatment for any illness, injury, or medical conditions arising out of: war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.
- Services rendered before the effective date of coverage.
- Services rendered after termination of coverage, except as provided under the plan's "Extension of Benefits upon Contract Termination."
- Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.
- Any denture or bridge replacement made necessary by reason of loss, theft, or alteration by an insured.
- Services in connection with any crown, inlay or onlay restoration or for any denture or bridge if treatment began prior to the insured's coverage under this certificate.
- Duplicate or temporary denture, crown, or bridge.
- Labial veneer restorations.
- General anesthesia and intravenous sedation administered exclusively for patient management or comfort.
- Charges for nitrous oxide.
- Services with respect to congenital (hereditary) or developmental malformations or cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or tower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- Prescribed drugs, premedication or analgesia.
- Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges for oral hygiene, plaque control, or diet instruction.
- Charges for orthodontia services, unless shown on the Benefit Summary.
- Charges for sterilization are included in the allowance for other covered dental procedures.
- Charges for biohazardous waste disposal are included in the allowance for other covered dental procedures
- Charges associated with accidental injuries to sound natural teeth.

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