Independence

Dental Benefit Summary

Independence Blue Cross (IBX) Dental PPO Summary of Benefits
AmeriHealth Caritas Standard Plan
1/1/2026

Plan Benefit Structure		
Benefit Maximum per Member per Calendar Year[1] Applies to: Type II & III Services	**In-Network (INN)** $1,000	**Out-of-Network (OON)** $1,000
Annual Deductible[1] Deductible waived for Type I services		
Individual	$50	$50
Family	$150	$150

Benefit Category	**In-Network (INN)**		**Out-of-Network (OON)**	
	Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
Type I: Preventive Covered Services				
Oral Exams	100%	0%	100%	0%
Prophylaxis				
Bitewing X-rays[3]				
Periapical X-rays[3]				
Full Mouth X-rays[3]				
Topical Fluoride				
Sealants				
Emergency Palliative Treatment				
Type II: Basic Covered Services[2]				
Fillings - Composite and Amalgam	70%	30%	70%	30%
Space Maintainers				
Endodontics[2]				
Root canals / Pulpal Therapy	70%	30%	70%	30%
Periodontics[2]				
Non-Surgical	70%	30%	70%	30%
Surgical (root planing and therapy)	50%	50%	50%	50%
Oral Surgery[2]				
Non-Surgical (simple extractions)	70%	30%	70%	30%
Surgical (extraction of impacted teeth)	50%	50%	50%	50%
Type III: Major Covered Services[2]				
Crowns/Inlays/Onlays	50%	50%	50%	50%
Prosthodontics - Bridges and Dentures				
Implants	Not Covered	Not Covered	Not Covered	Not Covered
Type IV: Orthodontia				
Child	Not Covered	Not Covered	Not Covered	Not Covered
Adult	Not Covered	Not Covered	Not Covered	Not Covered
Lifetime Maximum	Not Applicable		Not Applicable	

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OON Reimbursement	MAC
Provider Network	IBX Dental PPO Network

1. All per year benefits mean calendar year.
2. Plan determines that a less expensive alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition. The alternate treatment will produce a professionally satisfactory result; then the maximum the plan will allow will be the charge for the less expensive treatment.
3. Any combination of x-rays billed on the same date of treatment, cannot exceed the allowed amount for a full mouth x-ray benefit.
4. Please refer to Exclusion and Limitations for plan Details and coverage limitations.

In-Network Providers / Participating Dentists	Participating dentists have contracts with IBX or with IBX's independent dental network vendor. Participating dentists accept negotiated fees as payment in full for covered dental services, and file a member's claims with IBX. Members usually have lower out-of-pocket costs with participating dentists.
Out-of-Network Providers / Non-Participating Dentists	Non-participating dentists have no contract with IBX or with IBX's independent dental network vendor. Non-participating dentists set their own rates, can collect up to full billed charges from members, and have no obligation to file members' claims.
Optional Pre-Authorization	If your dentist has recommended services and you are concerned about coverage or costs, your dentist can ask IBX for a pre-treatment estimate, called a "pre-authorization." IBX will review your dentist's proposed treatment and send your dentist information explaining what services will be covered and your estimated out-of-pocket costs for these services. A pre-determination can help you better understand what will be covered and the amount you will need to pay.
Additional Cleaning	All diabetic and expecting mothers are eligible for coverage of one additional dental cleaning procedure or one additional periodontal maintenance procedure. For members who have enrolled in the program, extended preventive benefits will remain available for the duration of these conditions.

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IBX PPO Limitations

Diagnostic & Preventive Services

1. Oral Evaluations (Exams) - Comprehensive and periodic - one (1) of these services per 6 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more years. Limited problem focused and consultations - one (1) of these services per dentist per 12 months
2. Prophylaxis (cleaning, scaling and polishing teeth) - Two (2) per Calendar Year; one (1) additional cleaning is covered for expecting mothers or Diabetics
3. Topical fluoride - One (1) per 6 months under age nineteen (19)
4. Bitewing x-rays - Two (2) per calendar year
5. Periapical x-rays - no limitations
6. Full mouth or panoramic x-ray - One per 60 months
7. Sealants - one (1) per tooth per 3 calendar year(s) under age sixteen (16) on permanent first and second molars
8. Antibiotic injections administered by a dentist - no limitations
9. Space maintainers - one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop

Restorative Services

10. Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations) - Per tooth, per surface every 24 months

Oral Surgery

11. Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of periocoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/or stabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst - no limitations
12. Simple extraction of teeth - no limitations

Endodontic Services

13. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy - no limitations

Periodontics Services

14. Periodontic services, limited to periodontal maintenance - Periodontal maintenance following active periodontal therapy – two (2) per calendar year in addition to routine prophylaxis
15. Periodontic services, limited to root scaling and planing - One (1) per quadrant per 24 months
16. Periodontic services, limited to: occlusal adjustment performed with covered surgery; gingivectomy; osseous surgery including flap entry and closure - no limitations
17. Periodontic services, limited to pedicle or free soft tissue graft - One (1) Per 24 Months per Area of the Mouth
18. Periodontic services, limited to scaling in presence of generalized moderate or severe gingival inflammation - Full mouth, after oral evaluation and in lieu of a covered Prophylaxis (cleaning, scaling and polishing teeth), limited to one (1) per two (2) years

Repairs & Adjustments

19. Recementing bridges, inlays, onlays and crowns - After first 12 months of insertion and per 12 months per tooth thereafter
20. Repair of dentures or fixed bridgework - no limitations

Anesthesia

21. General anesthesia and analgesia, including intravenous sedation - no limitations
22. Infiltration of sustained release therapeutic drug - single or multiple sites - no limitations

Crowns, Inlays Onlays, Restorative Services

23. Crown build-up for non-vital teeth - no limitations
24. Restoration services, limited to replacement of existing inlay, onlay, or crown - Single crowns, inlays, onlays – not within five (5) calendar years of previous placement of any of the procedures in this category.
Replacement of natural tooth/teeth in an arch – not within 5 calendar years of a fixed partial denture, full denture or partial removable denture.
25. Restoration services, limited to stainless steel crowns - Up to age 14 (one per tooth per lifetime)
26. Restoration services, limited to post and core - Buildups and post and cores – not within five (5) calendar years of previous placement of any of the procedures in this category

Prosthetics

27. Prosthetic services, limited to initial placement of removable dentures or fixed bridges - no limitations
28. Prosthetic services, limited to replacement of removable dentures or fixed bridges - That cannot be repaired after five (5) years from the date of last placement.
29. Prosthetic services, limited to addition of teeth to existing partial denture - no limitations
30. Prosthetic services, limited to relining or rebasing of existing removable dentures - One per 24 months (only after 24 months from date of last placement)

Orthodontia

31. Orthodontia Services Not Covered - no limits when a covered benefit

Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.

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IBX PPO Exclusions

1. Services which are covered under worker's compensation or employer's liability laws or the PA Motor Vehicle Financial Responsibility Law.
2. Services which are not necessary and Appropriate Dental Services for the patient's dental health as determined by the plan.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs (with the exception of antibiotic injections administered by a dentist).
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of temporomandibular disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth including third molars.
12. Procedures not listed as covered services under this plan.
13. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances;
14. Athletic mouthguards;
15. Precision or semi-precision attachments;
16. Denture duplication;
17. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
18. Procedures that in the opinion of the plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the+A63 member's condition.
19. Preventive restorations.
20. Periodontal splinting of teeth by any method.
21. For which in the absence of insurance the Member would incur no charge.
22. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
23. Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).
24. Procedures that are:
    - · part of a service but are reported as separate services
    - · reported in a treatment sequence that is not appropriate
    - · misreported or that represent a procedure other than the one reported
25. Fees for broken appointments
26. Implants and related services, including implant removal.

The benefit summary in this flyer represents only a summary of the benefits and limitations of the dental plan and may not cover all of your dental expenses. For a complete description of your dental covered services, limitations, and exclusions, please refer to your contract or benefit booklet. If you need additional information, please call customer service at the number printed on the back of your member ID card.

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