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**2025 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option**  
**Section 5(g). Dental Benefits**  
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**Basic Option Dental Benefits**

Under Basic Option, we provide benefits for the services listed below. You pay a \$35 copayment for each evaluation, and we pay any balances up to the Maximum Allowable Charge previously described in this section. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, visit [www.fepblue.org/provider](http://www.fepblue.org/provider) to use our National Doctor & Hospital Finder, or call us at the customer service phone number on the back of your ID card.

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**Basic Option Dental Benefits**

**Clinical oral evaluations**

**Covered Service:** Periodic oral evaluation\*

**We Pay**

Preferred: All charges in excess of your \$35 copayment

Participating/Non-participating: Nothing

**You Pay**

Preferred: \$35 copayment per evaluation

Participating/Non-participating: You pay all charges

**Covered Service:** Limited oral evaluation

**We Pay**

Preferred: All charges in excess of your \$35 copayment

Participating/Non-participating: Nothing

**You Pay**

Preferred: \$35 copayment per evaluation

Participating/Non-participating: You pay all charges

**Covered Service:** Comprehensive oral evaluation\*

**We Pay**

Preferred: All charges in excess of your \$35 copayment

Participating/Non-participating: Nothing

**You Pay**

Preferred: \$35 copayment per evaluation

Participating/Non-participating: You pay all charges

\*Benefits are limited to a combined total of 2 evaluations per person per calendar year

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## Basic Option Dental Benefits

### Diagnostic imaging

**Covered Service:** Intraoral – complete series including bitewings (*limited to 1 complete series every 3 years*)

**We Pay**

Preferred: All charges in excess of your \$35 copayment

Participating/Non-participating: Nothing

**You Pay**

Preferred: \$35 copayment per evaluation

Participating/Non-participating: You pay all charges

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## Basic Option Dental Benefits

### Preventive

**Covered Service:** Prophylaxis – adult (*up to 2 per calendar year*)

**We Pay**

Preferred: All charges in excess of your \$35 copayment

Participating/Non-participating: Nothing

**You Pay**

Preferred: \$35 copayment per evaluation

Participating/Non-participating: You pay all charges

**Covered Service:** Prophylaxis – child (*up to 2 per calendar year*)

**We Pay**

Preferred: All charges in excess of your \$35 copayment

Participating/Non-participating: Nothing

**You Pay**

Preferred: \$35 copayment per evaluation

Participating/Non-participating: You pay all charges

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**Covered Service:** Topical application of fluoride or fluoride varnish – for children only (*up to 2 per calendar year*)

**We Pay**

Preferred: All charges in excess of your \$35 copayment

Participating/Non-participating: Nothing

**You Pay**

Preferred: \$35 copayment per evaluation

Participating/Non-participating: You pay all charges

**Covered Service:** Sealant – per tooth, first and second molars only (*once per tooth for children up to age 16 only*)

**We Pay**

Preferred: All charges in excess of your \$35 copayment

Participating/Non-participating: Nothing

**You Pay**

Preferred: \$35 copayment per evaluation

Participating/Non-participating: You pay all charges

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**Basic Option Dental Benefits**

**Covered Service:** *Not covered: Any service not specifically listed above*

**We Pay**

*Nothing*

**You Pay**

*All charges*

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