BlueCross BlueShield of Illinois

A Reason to Smile: 2025 BlueCare Dental℠ Coverage for Small Group Plans Is Here.

Small Group (1-50) Voluntary Plans

All Blue Cross and Blue Shield of Illinois small group qualified health plans include pediatric dental coverage as an essential health benefit embedded into the medical plan. Groups can purchase and layer a stand-alone dental plan with their existing health plan. This extends dental coverage to adult members age 19 and older.

Embedded Pediatric Dental Benefits

Pediatric dental coverage is an essential health benefit under the Affordable Care Act. Small groups and retail plans are required to offer dental coverage to child dependents up to age 19.

- Pediatric dental is treated as any other benefit in the medical plan – coinsurance, copayments and other cost-sharing rules apply. Pediatric dental charges feed into the medical deductible and out-of-pocket maximum.
- Groups no longer need to purchase an additional pediatric dental plan to meet ACA requirements.

Optional Coverage: Stand-Alone Voluntary Dental Plans[1]

Small groups can also purchase stand-alone voluntary dental coverage. These plans allow employers to offer family dental insurance to employees, expanding coverage beyond the pediatric benefits already included in the medical plan.

- Pediatric coverage and stand-alone voluntary dental plans are both offered by BCBSIL. This means members get the benefit of working with only one insurer.
- Stand-alone voluntary dental plans allow employees to purchase coverage for themselves and any dependents over age 19.
- Stand-alone voluntary dental plans may offer additional benefits to child dependents under age 19 than the pediatric coverage already embedded in the medical plan.
- Groups can purchase stand-alone voluntary dental coverage without having a medical plan in place, if they wish to only offer dental coverage to employees. Groups can also add stand-alone voluntary dental coverage to their BCBSIL medical plan, or to a medical plan from a different carrier.

2025 Voluntary Plans

	DILHR43		DILHM44		DILHR45		DILHM46		DILLR47		DILLR48		DILLM49		DILHR53		DILLR54		DILLM55		DILLM56		DILHM59		DILLR60[5]	
	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON
Deductible (3x Family)	$50		$50		$25	$75	$25	$75	$50		$50		$50		$50		$50		$50		$50	$100	$50		$50	
Annual Maximum	$1,500		$1,500	$1,000	$2,000		$750		$1,500		$1,500		$1,000		$1,500		$1,000		$1,000		$750		$1,500		$1,000	
Ortho Lifetime Maximum	$1,500		N/A		$2,000		N/A		N/A		$1,000		N/A		N/A		N/A		$1,000		N/A		$1,500		$1,000	
Diagnostic and Preventive[2]	100%		100%	80%	100%		100%		100%		100%		100%		100%		100%		100%		100%		100%		100%	
Misc Preventive Services	100%[2]		100%[2]	80%[2]	100%[2]		100%[2]		80%		80%		80%		100%[2]		80%		80%		80%	50%	100%[2]		80%	
Basic Restorative	80%		80%	60%	90%	80%	80%[3]		80%		80%		80%		80%		80%		80%		80%	50%	100%		80%	
Non-surgical Extractions, Non-surgical Periodontics, and Adjunctive Services	80%		80%	60%	90%	80%	N/A		80%		80%		80%		80%		80%		80%		80%	50%	100%		80%	
Endodontics	80%		80%	60%	90%	80%	N/A		50%		50%		50%		80%		50%		50%		50%		100%		50%	
Oral Surgery	80%		80%	60%	90%	80%	N/A		50%		50%		50%		80%		50%		50%		50%		100%		50%	
Surgical Periodontal[4]	80%		80%	60%	90%	80%	N/A		50%		50%		50%		80%		50%		50%		50%		100%		50%	
Major Restorative and Prosthodontics[4]	50%		50%	40%	60%	50%	N/A		50%		50%		50%		50%		50%		50%		50%		60%		50%	
Implants	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A	
Orthodontics[2]	50%		N/A		50%		N/A		N/A		50%		N/A		N/A		N/A		50%		N/A		50%		50%	
OON Reimbursement	90th R&C		MAC		90th R&C		MAC		90th R&C		90th R&C		MAC		90th R&C		90th R&C		MAC		MAC		MAC		90th R&C	

For information on rates, contact your BCBSIL Account Representative.

NOTE: DILLR47 and DILLR48 are new for 2025.

IN = In-network; OON = Out-of-network

1. This document does not contain a complete listing of the exclusions, limitations and conditions that apply to the benefits shown. For full information, refer to the benefit booklet.
2. Waived Deductible applies to this service.
3. Only Basic Restorative Services are covered.
4. 12-month waiting period applies.
5. Preventive services will not count toward maximum annual benefit.

Examples

Members' out-of-pocket costs can vary depending on whether they purchase a stand-alone family plan or simply use the embedded pediatric dental coverage included in their medical plan. Here are some sample services and member costs:

Service	Cost of Service	Member with Embedded Benefit Pays	Plan DILHR43
Deductible		$3,000	$50
Preventive: cleaning, exams, and X-ray	$200	$200 toward medical deductible and coinsurance. No adult coverage	$0*
Basic: filling	$140	$140 toward medical deductible and coinsurance. No adult coverage	**Child or adult member pays $68** *($140 - $50 deductible = $90, then 20% of $90 balance = $18 plus $50 deductible)***
Major:** root canal	$900	$900 toward medical deductible and coinsurance. No adult coverage	**Child or adult member pays $475** *($900 - $50 deductible = $850, then 50% of $850 balance = $425 plus $50 deductible)***

Note: The dollar amounts shown are for illustrative purposes only. Check with your provider and your benefit booklet for provider charges, deductible, coinsurance and dollar maximums that may apply.

Get more information at bcbsil.com or contact your BCBSIL Account Representative.

*Deductible is waived for preventive services.
**Calculations assume deductible had not been previously met.
***A 12-month waiting period applies on Major Services for this plan.