

# SIGNATUREBLUE

GROUP DENTAL PLANS



Experience the value of SignatureBlue.



## NEW FOR 2026:

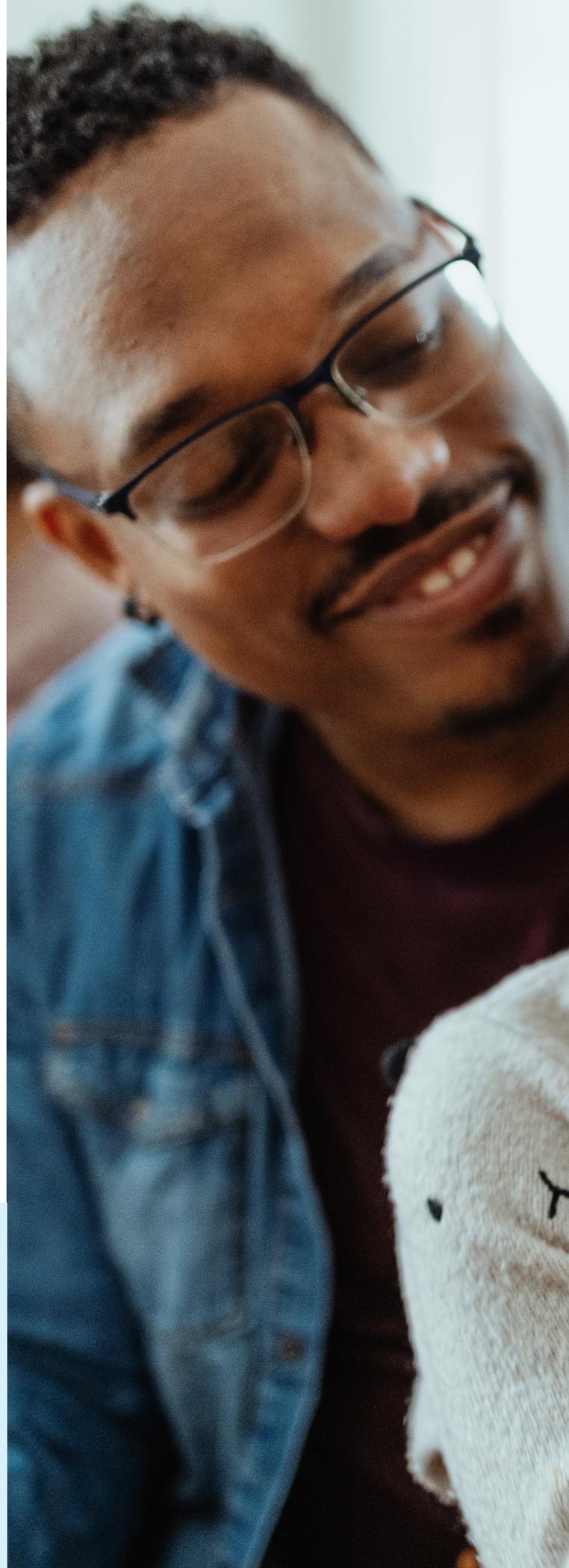
- **New voluntary plan options and rating**
- **Lower contribution requirements** on contributory plans
- **Lower participation requirements**
- **Now accepting stand-alone dental business**
- **One rate for all** – No surcharges for:
  - Not having medical with us
  - Not having prior dental coverage
  - Urban vs. rural rating



## KNOW YOUR PLAN OPTIONS!

All eleven plans are available to groups with more than ten enrolled contracts.

Groups with two to nine enrolled can access all plans except those with orthodontic coverage.





## WHY SIGNATUREBLUE?



Bundling discount: Fully insured groups receive **0.5% off the medical premium** for each vision or dental plan that is purchased through BCBSNE, **up to 1.5%**.

ASO groups can take **\$0.25 off their administrative fees** for each dental and/or vision product purchased through BCBSNE, **up to \$0.75**.



One bill, one ID card



Low monthly premiums



\$1,000 / \$1,500 / \$2,000  
calendar year max options



Child and adult  
orthodontic options



Passive plan options (same cost  
share in-network and out-of-  
network – great for rural areas)



Flexible plan designs (endodontic/  
periodontic as Class B or C)



Robust provider network



Experience rating for groups  
with 100+ enrolled



Custom plan options for groups  
with 250+



Award-winning customer service

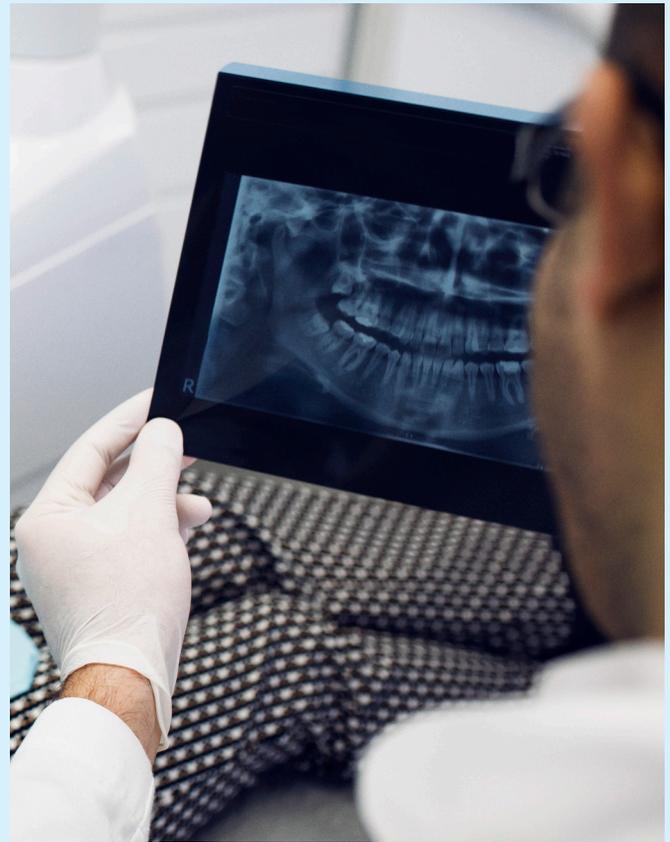


## OUR DENTAL NETWORK MAKES IT EASY TO GET CARE.

Your employees can use NETwork BLUE Dental in Nebraska or the Dental GRID network across all 50 states. That means they can find a dentist whether they're at home or traveling.

They can see any licensed dentist, but there are benefits to choosing one in our network:

- They won't pay more than our set prices for covered services.
- Dentists file claims for them—no paperwork.
- All network dentists are checked and approved.



## 2026 SIGNATUREBLUE DENTAL PLANS

Dental Option	Calendar Year Deductible INN Single / Family	Calendar Year Maximum	Coverage A INN / OON	Coverage B INN / OON	Coverage C INN / OON	Endo / Perio	Coverage D - Orthodontics*		
							Child Ortho	Adult Ortho	Lifetime Maximum
Option 1	\$0 / \$0	\$1,000	100% / 60%	80% / 50%	NC / NC	NC	NC	NC	NC
Option 3	\$50 / \$100	\$2,000	100% / 60%	80% / 50%	50% / 50%	B	NC	NC	NC
Option 4	\$50 / \$100	\$1,000	100% / 60%	80% / 50%	50% / 50%	C	NC	NC	NC
Option 5	\$50 / \$100	\$2,000	100% / 60%	80% / 50%	50% / 50%	C	NC	NC	NC
Option 9	\$50 / \$100	\$2,000	100% / 60%	80% / 50%	50% / 50%	C	50%	NC	\$1,500
Option 11	\$50 / \$100	\$2,000	100% / 60%	80% / 50%	50% / 50%	B	50%	50%	\$1,500
Option 13	\$50 / \$100	\$2,000	100% / 60%	80% / 50%	50% / 50%	C	50%	50%	\$1,500
Option 15	\$50 / \$100	\$1,000	80% / 80%	80% / 80%	50% / 50%	C	NC	NC	NC
Option 18	\$50 / \$100	\$1,500	100% / 100%	80% / 80%	50% / 50%	B	50%	NC	\$1,500
Option 20	\$50 / \$100	\$1,500	100% / 100%	80% / 80%	50% / 50%	B	50%	50%	\$1,500
Option 21	\$50 / \$100	\$1,500	100% / 100%	80% / 80%	50% / 50%	C	50%	50%	\$1,500

\*Plans with orthodontic coverage are only available with 10 or more enrolled contracts. Groups with 2-9 enrolled contracts can select Options 1, 3, 4, 5 or 15.



## COVERED SERVICES

### COVERAGE A SERVICES

#### Preventive and diagnostic dentistry

Under Coverage A, benefits are available for (but not limited to) the following covered services:

- Two comprehensive and/or periodic oral examinations per calendar year
- Two prophylaxis, including cleaning, scaling and polishing of teeth per calendar year
- Two topical fluoride applications per calendar year up to age 16<sup>1</sup>
- Two fluoride varnishes per calendar year<sup>1</sup>
- Sealants, once every four calendar years<sup>1</sup>
- Space maintainers<sup>1</sup>
- Pulp vitality tests
- Dental X-rays<sup>2</sup>
  - One full mouth or panorex series of X-rays every three calendar years
  - One set of four supplemental bitewing X-rays in a calendar year

1 Coverage available for dependents under the age of 16 only

2 X-rays related to services provided under a different coverage classification are excluded under Coverage A benefits

### COVERAGE B SERVICES

#### Maintenance and simple restorative dentistry and oral surgery

Under Coverage B, benefits are available for (but not limited to) the following covered services:

##### Oral surgery consisting of:

- Simple and impacted extractions<sup>1</sup>
- Removal of dental cysts and tumors

##### Other services:

- General anesthesia (medically necessary)
- Restorations of silver and/or composite materials (fillings)
- Palliative treatment
- Repair of dentures, bridges, crowns and cast restorations
- Problem-focused and/or emergency oral examinations

1 Extractions for orthodontia services are excluded

### COVERAGE C SERVICES

#### Complex restorative dentistry, periodontics and endodontics

Under Coverage C, benefits are available for (but not limited to) the following covered services:

##### Complex restorative dentistry:

- Crowns
- Inlays/onlays
- Installation of permanent bridges
- Dentures – full and partial
- Denture adjustments
- Core buildup

##### Periodontic services consisting of:<sup>1</sup>

- Up to four periodontic cleanings per calendar year
- Gingivectomy
- Gingival curettage
- Osseous surgery
- Treatment of acute infection and oral lesions
- Soft tissue allografts

##### Endodontic services consisting of:<sup>1</sup>

- Pulp cap
- Vital pulpotomy
- Root canals<sup>2</sup>
- Apical curettage

1 Depending on plan option, these services may be under Coverage B or Coverage C (for groups with 51+ eligible employees)

2 Includes treatment plan, diagnostic X-rays, clinical procedures and follow-up care

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# COVERAGE D SERVICES

## Orthodontic Dentistry

Under Coverage D, benefits are available for (but not limited to) the following covered services:

- Cephalometric X-rays
- Extractions

## NONCOVERED SERVICES

This brochure contains only a partial listing of the limitations and exclusions that apply to SignatureBlue coverage. A more complete list may be found in the master group contract.

Benefits are not available for the following:

- Services not covered by this contract
- Services for treatment of Temporomandibular (jaw) joint
- Services with respect to congenital malformations (including, but not limited to missing teeth) or primarily for cosmetic or aesthetic purposes
- Magnetic resonance imaging and computed tomography (CT) scans
- Replacement of the third molars with prostheses
- Implants or any procedure associated with the preparation for, maintenance of or placement or removal of implants
- Removal of dental cysts and tumors (including biopsies and excisions of mouth lesions)
- Surgical incision and drainage of dental abscess
- Analgesia, desensitizing medicament, local anesthesia, intravenous sedation and nitrous oxide
- Enamel microabrasion
- Odontoplasty
- Whitening agents, tooth bonding and veneers
- Placement or removal of sedative filling, base or liner used under a restoration
- Coping
- Tooth transplantation
- Any service, supply or appliance, including orthodontic or dental implants, for dental treatment of naturally healthy teeth required as a direct result of an accidental injury
- Emergency tracheotomy
- Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments
- Services considered to be investigative, not medically necessary, experimental, cosmetic or obsolete
- Injectable drugs or drugs dispensed in a provider's office
- Charges for services provided by a hospital, ambulatory surgical facility or any other facility charge
- Reduction of a complete dislocation or fracture of the Temporomandibular Joint of the jaw





Blue Cross and Blue Shield of Nebraska is an independent licensee of the Blue Cross Blue Shield Association. 60-327-1-508 (09-24-25)