# BlueCare® Dental

**PPO - PRG (Low)**

BlueCross BlueShield of Illinois

# Parker Restaraunt Group

Effective: 1/1/2025 - 12/31/2025

***The following is a listing of common services available through your BlueCare Dental PPO network. The member's share of the cost is determined by whether care is received from a contracting or non-contracting provider.***

This information only provides highlights of this program. Please refer to the BlueCare Dental Certificate for additional benefit information. *Passive PPO's provide identical benefits for 'contracting' and 'non-contracting' providers.*

## DENTAL BENEFIT HIGHLIGHTS

| Program Basics | Contracting Provider | Non-Contracting Provider* UCR 90th |
|---|---|---|
| ***Benefit Period Maximum: Calendar Year*** | $750.00 | $750.00 |
| ***Deductible: Calendar Year*** | $50.00 Individual<br>$150.00 Family | $50.00 Individual<br>$150.00 Family |
| ***Three Month Deductible Carryover Applies*** | Yes ☐ No ☑ | Yes ☐ No ☑ |
| ***Prior Carrier Deductible Credit Applies*** | Yes ☐ No ☑ | Yes ☐ No ☑ |
| **Services** | | |
| ***Diagnostic Services (Deductible does not apply)***<br>Periodic oral evaluations<br>Problem focused oral evaluations<br>Comprehensive oral evaluations | 100% | 100% |
| ***Preventive Services (Deductible does not apply)***<br>Prophylaxis (cleanings)<br>Topical fluoride applications | 100% | 100% |
| ***Diagnostic Radiographs (Deductible does not apply)***<br>Full-mouth and panoramic films<br>Bitewing films<br>Periapical films | 100% | 100% |
| ***Miscellaneous Preventive Services (Deductible does not apply)***<br>Sealants<br>Space maintainers | 100% | 100% |
| ***Basic Restorative Dental Services***<br>Amalgams<br>Resin-based composite restorations | 80% | 80% |
| ***Non-Surgical Extractions***<br>Removal of retained coronal remnants<br>Removal of erupted tooth or exposed root | 80% | 80% |
| ***Non-Surgical Periodontic Services***<br>Periodontal scaling and root planing<br>Full-mouth debridement<br>Periodontal maintenance procedures | Not Covered | Not Covered |

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| | | |
|---|---|---|
| ***Adjunctive Services*** | | |
| Palliative treatment (emergency) | 80% | 80% |
| Deep sedation / general anesthesia | | |
| ***Endodontic Services*** | | |
| Therapeutic pulpotomy and pulpal debridement | Not Covered | Not Covered |
| Root canal therapy | | |
| Apexification/recalcification | | |
| ***Oral Surgery Services*** | | |
| Surgical tooth extractions | Not Covered | Not Covered |
| Alveoloplasty and vestibuloplasty | | |
| Excision of benign odontogenic tumor/cyst | | |
| Excision of bone tissue | | |
| Incision and drainage of an intraoral abscess | | |
| (Bony impactions typically covered under medical plan) | | |
| ***Surgical Periodontal Services*** | | |
| Gingivectomy or gingivoplasty and gingival flap procedures | Not Covered | Not Covered |
| Clinical crown lengthening | | |
| Osseous surgery | | |
| Osseous grafts | | |
| Soft tissue grafts/allografts | | |
| Distal or proximal wedge procedure | | |
| ***Major Restorative Services*** | | |
| Single crown restorations | Not Covered | Not Covered |
| Inlay/onlay restorations | | |
| Labial veneer restorations | | |
| Crowns placed over implants | | |
| ***Prosthodontic Services*** | | |
| Complete and removable partial dentures | Not Covered | Not Covered |
| Denture reline/rebase procedures | | |
| Fixed bridgework | | |
| Prosthetics placed over implants | | |
| Implants Yes ☐ No ☑ | | |
| ***Misc. Restorative & Prosthodontic Services*** | | |
| Prefabricated crowns | Not Covered | Not Covered |
| Recementations | | |
| Post and core, pin retention and crown/bridge repairs | | |
| Adjustments | | |
| ***Orthodontics (Deductible Not Waived)*** | | |
| Orthodontic Diagnostic Procedures and Treatment: | Not Covered | Not Covered |

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**Insured: Coordination of Benefits**

☑ Birthday rule applies

Non-duplication of benefits (COB):

☐ Yes (all benefits combined not to exceed benefits of this program)

☑ No (standard - all benefits combined not to exceed total charges)

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Claim filing time limit:

☑ Within 365 days of the date of service

☐ End of the year following the year of service

☐ Two years from the date of service

☐ Other (explain in additional provisions section below)

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**Additional Provisions:** Changes from standard to non-standard benefits (with CBSR / AdHoc approval). Account Structure changes, i.e., new group & section numbers. Also, indicate renewal benefit changes and the effective date of that change.

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☐ **BlueMax Advantage - Available only for 151+**

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**Transfer-in (Takeover Credit): ☐ Yes ☑ No : $** *enter amount* **and services being Transferred-In**

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**Missing Tooth Exclusion applies:**

☐ **Yes**

An exclusion applies to expenses involving the replacement of teeth that were missing prior to the effective date of coverage, except when a participant has had continuous coverage for the following number of months under a group dental care contract with BCBSIL, a previous group dental contract or a combination of the two. Plans must include major services (prosthetic benefits)

☐ 24 months

☐ 99 months (exclusion permanently applies)

**Does exclusion apply to initial enrollees?**

☐ Yes (Same rules as above apply)

☐ No (Initial enrollees receive immediate coverage)

☑ **No Exclusion**

All teeth covered beginning on first day of coverage

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**Enhanced Dental Benefit: ☑ Yes ☐ No**

Enhanced Benefit allows groups to provide additional dental benefits to members with specific medical conditions. The group must also have their medical coverage through BCBS

**Select Covered Conditions:**

☑ Cardiovascular disease, Diabetes or Pregnancy (standard grouping)

☑ Pre-Diabetes (requires standard grouping)

Additional benefit for one of the following:

- Scaling & Root Planing
- Periodontal Maintenance
- Cleaning

**Apply toward annual maximum:** ☑ Applies ☐ Does not apply

Additional Enhanced Benefit provisions require Division of Insurance and/or CBSR approval.

Any customization should be noted in the Additional provisions section.

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**Available with 1/1/2020 effective dates:**
**Preventive Services selected below will not apply to the annual maximum**

- ☐ **Diagnostic Services**
- ☐ **Preventive Services**
- ☐ **Diagnostic Radiographs**
- ☐ **Miscellaneous Preventive Services**

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**Benefit Waiting Period - ☑ No or ☐ Yes (the information below is required per group requested)**
**NOTE: If a benefit waiting period applies; Waiting period is waived for existing group dental plans and/or transfers group.**
Members must be continuously covered under this policy for [xx] months before being eligible for the following Covered Services:

- ☐ Oral surgery
- ☐ Endodontics
- ☐ Non-Surgical Periodontal Services
- ☐ Surgical Periodontal Services
- ☐ Major Restorative Services
- ☐ Prosthodontic Services
- ☐ Miscellaneous Restorative and Prosthodontic Services
- ☐ Orthodontic Services

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*Each time you need dental care you can choose to:

| See a Contracting Provider | See a Non-Contracting Provider |
|---|---|
| • Your out-of-pocket cost will generally be the least amount because BlueCare Providers have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses<br>• You are not required to file claim forms<br>• You are not balance billed for costs exceeding the BCBSIL Allowable Amount for BlueCare Dentists | • Your out-of-pocket cost may be greater because Non-Contracting Providers have not entered into a contract with BCBSIL to accept any Allowable Amount determination as payment for Eligible Dental Expenses<br>• You are required to file claim forms<br>• You are balance billed for costs exceeding the BCBSIL Allowable Amount<br>• Non-contracting provider reimbursement UCR 90th |

**Employee Information**

- This is a general summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.
- The following eligibility provisions apply:
  - Dependent children are covered to age 26. Disabled dependent children can be covered beyond age 26.
  - Open enrollment - employees and/or dependents not presently covered may enroll for dental 31 days prior to the anniversary date.

**When the course of treatment will be in excess of $300, a predetermination request should be submitted to BCBSIL in advance of treatment.**

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Enter Name
Group Executive Name and Title
(Please type or print)

_____ Signature

_____ Date

Enter Name
Agent of Record Name
(Please type or print)

_____ Signature

_____ Date

Enter Name
BCBSIL Representative Name
(Please type or print)

_____ Signature

_____ Date