

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 | \$1,500.00 | \$1,500.00 |
| Deductible: Calendar Year | \$50.00 Individual \$150.00 Family | \$50.00 Individual \$150.00 Family |
| Three Month Deductible Carryover Applies | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Prior Carrier Deductible Credit Applies | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Services | | |
| Diagnostic Services (Deductible does not apply) | | |
| Periodic oral evaluations | 100% | 100% |
| Problem focused oral evaluations | | |
| Comprehensive oral evaluations | | |
| Preventive Services (Deductible does not apply) | | |
| Prophylaxis (cleanings) | 100% | 100% |
| Topical fluoride applications | | |
| Diagnostic Radiographs (Deductible does not apply) | | |
| Full-mouth and panoramic films | 100% | 100% |
| Bitewing films | | |
| Periapical films | | |
| Miscellaneous Preventive Services (Deductible does not apply) | | |
| Sealants | 100% | 100% |
| Space maintainers | | |
| Basic Restorative Dental Services | | |
| Amalgams | 80% | 80% |
| Resin-based composite restorations | | |
| Non-Surgical Extractions | | |
| Removal of retained coronal remnants | 80% | 80% |
| Removal of erupted tooth or exposed root | | |
| Non-Surgical Periodontic Services | | |
| Periodontal scaling and root planing | 50% | 50% |
| Full-mouth debridement | | |
| Periodontal maintenance procedures | | |

Adjunctive Services

| | | |
|------------------------------------|-----|-----|
| Palliative treatment (emergency) | 80% | 80% |
| Deep sedation / general anesthesia | | |

Endodontic Services

| | | |
|--|-----|-----|
| Therapeutic pulpotomy and pulpal debridement | 50% | 50% |
| Root canal therapy | | |
| Apexification/recalcification | | |

Oral Surgery Services

| | | |
|--|-----|-----|
| Surgical tooth extractions | 50% | 50% |
| 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 | | |
| Clinical crown lengthening | | |
| Osseous surgery | 50% | 50% |
| Osseous grafts | | |
| Soft tissue grafts/allografts | | |
| Distal or proximal wedge procedure | | |

Major Restorative Services

| | | |
|-----------------------------|-----|-----|
| Single crown restorations | | |
| Inlay/onlay restorations | 50% | 50% |
| Labial veneer restorations | | |
| Crowns placed over implants | | |

Prosthodontic Services

| | | |
|--|-----|-----|
| Complete and removable partial dentures | | |
| Denture reline/rebase procedures | | |
| Fixed bridgework | 50% | 50% |
| Prosthetics placed over implants | | |
| Implants Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |

Misc. Restorative & Prosthodontic Services

| | | |
|---|-----|-----|
| Prefabricated crowns | | |
| Recementations | 50% | 50% |
| Post and core, pin retention and crown/bridge repairs | | |
| Adjustments | | |

Orthodontics (Deductible Waived)

| | | |
|---|-----|-----|
| Orthodontic Diagnostic Procedures and Treatment: | 50% | 50% |
| Adults eligible Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| Dependent Children eligible Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| Age Limitation 19 | | |

Lifetime Maximum Benefit per Participant

| | |
|------------|------------|
| \$1,500.00 | \$1,500.00 |
|------------|------------|

BlueCare[®] Dental

PPO - PRG (High)



BlueCross BlueShield of
Illinois

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)

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)

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.

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

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

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

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.

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

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

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

See a 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
- You are not required to file claim forms
- You are not balance billed for costs exceeding the BCBSIL Allowable Amount for BlueCare Dentists

See a Non-Contracting Provider

- 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
- You are required to file claim forms
- You are balance billed for costs exceeding the BCBSIL Allowable Amount
- 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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Illinois**

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