BlueCare® Dental

PPO LOW

BlueCross BlueShield of Illinois

Herscher SD 2

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.

DENTAL BENEFIT HIGHLIGHTS

Program Basics	Contracting Provider	Non-Contracting Provider* U&C 90th
Benefit Period Maximum: *Calendar Year*	$500.00	$500.00
Deductible: *Calendar Year*	$25.00 **Individual** $75.00 **Family**	$25.00 **Individual** $75.00 **Family**
Three Month Deductible Carryover Applies	Yes ☐ No☒	Yes ☐ No☒
Prior Carrier Deductible Credit Applies	Yes ☒ No☐	Yes ☒ No☐
Services		
Diagnostic Services (Deductible applies) Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	100%	100%
Preventive Services (Deductible applies) Prophylaxis (cleanings) Topical fluoride applications	100%	100%
Diagnostic Radiographs (Deductible applies) Full-mouth and panoramic films Bitewing films Periapical films	100%	100%
Miscellaneous Preventive Services (Deductible applies) Sealants Space maintainers	100%	100%
Basic Restorative Dental Services Amalgams Resin-based composite restorations	100%	80%
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	100%	80%
Non-Surgical Periodontic Services Periodontal scaling and root planing Full-mouth debridement Periodontal maintenance procedures	100%	80%

BlueCare® Dental

PPO LOW

BlueCross BlueShield of Illinois

Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia	100%	80%
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	0%	0%
Oral Surgery Services Surgical tooth extractions 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)	0%	0%
Surgical Periodontal Services Gingivectomy or gingivoplasty and gingival flap procedures Clinical crown lengthening Osseous surgery Osseous grafts Soft tissue grafts/allografts Distal or proximal wedge procedure	0%	0%
Major Restorative Services Single crown restorations Inlay/onlay restorations Labial veneer restorations Crowns placed over implants	0%	0%
Prosthodontic Services Complete and removable partial dentures Denture reline/rebase procedures Fixed bridgework Prosthetics placed over implants Implants Yes ☒ No☐	0%	0%
Miscellaneous Restorative and Prosthodontic Services Prefabricated crowns Recementations Post and core, pin retention and crown/bridge repairs Adjustments	0%	0%
Orthodontics **Choose an item.** Orthodontic Diagnostic Procedures and Treatment: Adults eligible: ☒ No ☐ Yes Dependent Children eligible: ☐ No ☒ Yes If yes age limitation: 19 Standard **Lifetime Maximum Benefit per Participant**	Not Covered% **$**	Not Covered% **$**

BlueCare® Dental

PPO LOW

BlueCross BlueShield of Illinois

Insured: Coordination of Benefits (COB): ☒ Birthday rule applies (standard)
ASO: Coordination of Benefits (COB):
☐ Birthday rule (standard)
☐ Gender rule

Insured and ASO: 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 (standard)
☐ 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+**

Graduated Dental Benefit Maximum: $ Enter amount.

Graduated Benefit Start Date: Enter date. **Number of Increments:** Enter number.

In-Network Increment Amount: **$** Enter amount.

Out-of-Network Increment Amount: $ Enter amount.

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

Missing Tooth Exclusion applies:

☐ **Yes** (standard)

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 (standard)
☐ 99 months (exclusion permanently applies)

Does exclusion apply to initial enrollees?
☐ *Yes* (Same rules as above apply)
☐ *No* (Initial enrollees receive immediate coverage standard)

☒ **No Exclusion**

All teeth covered beginning on first day of coverage

BlueCare® Dental

PPO LOW

BlueCross BlueShield of Illinois

Enhanced Dental Benefit - ☒ Yes (standard) ☐ 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 (standard) ☐ 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.

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 request) Effective Date: Enter date.
NOTE: IF A BENEFIT WAITING PERIOD APPLIES; WAITING PERIOD WAIVED FOR EXISTING GROUP DENTAL PLANS AND/OR TRANSFERS GROUPS.
Member must be continuously covered under this policy for [3,6,9,12,18,24] 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	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** • **You are not required to file claim forms** • **You are not balance billed for costs exceeding the BCBSIL Allowable Amount for BlueCare Dentists**	• **Choose an item.** • **You are required to file claim forms)** • **You are balance billed for costs exceeding the BCBSIL Allowable Amount** • **Non-contracting provider reimbursement** Choose an item