

Monmouth – Roseville CUSD #238

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* U&C 90th
Benefit Period Maximum: Calendar Year	\$1,500	\$1,500
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 Choose an item. Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	100%	100%
Preventive Services Choose an item. Prophylaxis (cleanings) Topical fluoride applications	100%	100%
Diagnostic Radiographs Choose an item. Full-mouth and panoramic films Bitewing films Periapical films	100%	100%
Miscellaneous Preventive Services Choose an item. Sealants Space maintainers	100%	100%
Basic Restorative Dental Services Amalgams Resin-based composite restorations	80%	80%
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	80%	80%
Non-Surgical Periodontic Services Periodontal scaling and root planing Full-mouth debridement Periodontal maintenance procedures	50%	50%

PPO

<p>Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia</p>	50%	50%
<p>Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification</p>	50%	50%
<p>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)</p>	Choose an item. %	Choose an item. %
<p>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</p>	50%	50%
<p>Major Restorative Services Single crown restorations Inlay/onlay restorations Labial veneer restorations Crowns placed over implants</p>	50%	50%
<p>Prosthodontic Services Complete and removable partial dentures Denture reline/rebase procedures Fixed bridgework Prosthetics placed over implants Implants Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	50%	50%
<p>Miscellaneous Restorative and Prosthodontic Services Prefabricated crowns Recementations Post and core, pin retention and crown/bridge repairs Adjustments</p>	50%	50%
<p>Orthodontics Choose an item. Orthodontic Diagnostic Procedures and Treatment: Adults eligible: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Dependent Children eligible: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes If yes age limitation: 19 Standard</p> <p>Lifetime Maximum Benefit per Participant</p>	50%	50%
	\$1,500.00	\$1,500.00

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

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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
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 U&C 90th