

## East Bank Club

Effective: 6/1/2024 - 5/31/2025

**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
<b>Benefit Period Maximum: Calendar Year</b>	\$1,500.00	\$1,000.00
<b>Deductible: Calendar Year</b>	\$50.00 Individual \$150.00 Family	\$50.00 Individual \$150.00 Family
<b>Three Month Deductible Carryover Applies</b>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>Prior Carrier Deductible Credit Applies</b>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>Services</b>		
<b>Diagnostic Services (Deductible does not apply)</b>		
Periodic oral evaluations	100%	100%
Problem focused oral evaluations		
Comprehensive oral evaluations		
<b>Preventive Services (Deductible does not apply)</b>		
Prophylaxis (cleanings)	100%	100%
Topical fluoride applications		
<b>Diagnostic Radiographs (Deductible does not apply)</b>		
Full-mouth and panoramic films	100%	100%
Bitewing films		
Periapical films		
<b>Miscellaneous Preventive Services (Deductible does not apply)</b>		
Sealants	100%	100%
Space maintainers		
<b>Basic Restorative Dental Services</b>		
Amalgams	90%	80%
Resin-based composite restorations		
<b>Non-Surgical Extractions</b>		
Removal of retained coronal remnants	90%	80%
Removal of erupted tooth or exposed root		
<b>Non-Surgical Periodontic Services</b>		
Periodontal scaling and root planing	90%	80%
Full-mouth debridement		
Periodontal maintenance procedures		

## **Adjunctive Services**

Palliative treatment (emergency)	90%	80%
Deep sedation / general anesthesia		

## **Endodontic Services**

Therapeutic pulpotomy and pulpal debridement	90%	80%
Root canal therapy		
Apexification/recalcification		

## **Oral Surgery Services**

Surgical tooth extractions	90%	80%
Alveoloplasty and vestibuloplasty		
Excision of benign odontogenic tumor/cyst		
Excision of bone tissue		
Incision and drainage of an intraoral abscess		

## **Surgical Periodontal Services**

Gingivectomy or gingivoplasty and gingival flap procedures		
Clinical crown lengthening		
Osseous surgery	90%	80%
Osseous grafts		
Soft tissue grafts/allografts		
Distal or proximal wedge procedure		

## **Major Restorative Services**

Single crown restorations		
Inlay/onlay restorations	60%	50%
Labial veneer restorations		
Crowns placed over implants		

## **Prosthodontic Services**

Complete and removable partial dentures		
Denture reline/rebase procedures		
Fixed bridgework	60%	50%
Prosthetics placed over implants		
Implants Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		

## **Misc. Restorative & Prosthodontic Services**

Prefabricated crowns		
Recementations	60%	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	

<b>Lifetime Maximum Benefit per Participant</b>	<b>\$1,500.00</b>	<b>\$1,000.00</b>
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# BlueCare<sup>®</sup> Dental

**PPO - East Bank Club**



BlueCross BlueShield of  
Illinois

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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 Provision:** ☐ Yes ☒ No (add contractual language below)

An exclusion will apply to expenses involving the replacement of teeth that were missing prior to the effective date of the dental contract.

**All other benefits**

- Any participant who has been continuously covered for 24 months under a group dental care contract with BCBSIL or a combination of coverage of BCBSIL and the previous group dental care contract by the employer, which included prosthetic benefits.
- A partial or full denture or fixed bridge which includes replacement of a missing tooth which was extracted after coverage becomes effective.

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

Enhanced Benefit is a dental benefit that allows groups to provide additional dental benefits to member with specific medical conditions such as Cardiovascular disease, Diabetes or Pregnancy. The group must also have their medical coverage through BCBS.

Benefit for one of the following:

- Scaling & Root Planning
- Periodontal Maintenance
- One Additional 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