Capital BLUE

BlueCross Dental℠
Dental PPO Loyalty Plan

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Individual Dental Policy and Coverage Schedule for the applicable benefit period.

Adult (Age 19 and over) Highlights	**Adult (Age 19 and over) Member Cost-Sharing**					
NETWORK: BlueCross *Dental* PPO (Individuals)						
DEDUCTIBLE						
Per benefit period	$50 per member $150 per family					
BENEFIT PERIOD PROGRAM MAXIMUM						
When the program maximum is reached, the Member pays 100% until benefit period ends.	$1,000 per member per benefit period					
WAITING PERIODS						
	None					
	Participating Providers			**Nonparticipating Providers**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
DIAGNOSTIC AND PREVENTIVE						
Routine Exams (two per calendar year)	Covered in full	Covered in full	Covered in full	20%	20%	20%
Bitewing X-rays (two per calendar year)	Covered in full	Covered in full	Covered in full	20%	20%	20%
Prophylaxis (two per calendar year)	Covered in full	Covered in full	Covered in full	20%	20%	20%
Palliative Emergency Treatment (acute condition requiring immediate care)	Covered in full	Covered in full	Covered in full	20%	20%	20%
BASIC SERVICES						
Amalgam and composite fillings	60%	40%	20%	80%	60%	40%
Simple Extractions	60%	40%	20%	80%	60%	40%
Periapical X-rays (as required)	60%	40%	20%	80%	60%	40%
Full Mouth or Panoramic X-rays (one per 36 months)	60%	40%	20%	80%	60%	40%
MAJOR SERVICES						
Oral Surgery (extraction and oral surgery procedures)	80%	70%	50%	90%	90%	70%
Endodontics (procedures for pulpal therapy and root canal filling)	80%	70%	50%	90%	90%	70%
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	80%	70%	50%	90%	90%	70%
General anesthesia (when provided in connection with covered oral surgery or periodontal surgery)	80%	70%	50%	90%	90%	70%
Major Restorative (crowns, inlays, onlays)	80%	70%	50%	90%	90%	70%
Prosthodontics • Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures; prosthetic replacement limited to once in five years	80%	70%	50%	90%	90%	70%

In-Network providers agree to accept our allowed amount as payment in full—often less than their normal charge. If you visit an Out-of-Network provider, you are responsible for paying the deductible, coinsurance and the difference between the Out-of-Network provider's charges and the allowed amount.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in other health benefits coverage you may have.

Paper claims may be submitted to the following address: BlueCross Dental; PO Box 1126; Elk Grove Village, IL 60009.

Electronic claims may be submitted using Payor ID CBC01.

Benefits are issued by Capital Advantage Assurance Company®, a subsidiary company of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

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Pediatric (Under Age 19) Highlights	**Pediatric (Under age 19) Member Cost-Sharing**	
NETWORK: BlueCross *Dental* PPO (Individuals)		
DEDUCTIBLE	**Participating Providers**	**Nonparticipating Providers**
Per benefit period Deductible waived for diagnostic and preventive.	$75 per member	
OFFICE VISIT COPAYMENT	$10 per visit	
OUT OF POCKET MAXIMUM		
When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowed amount until the benefit period ends.	$350 per member $700 per family	None
BENEFIT PERIOD PROGRAM MAXIMUM		
When the program maximum is reached, the Member pays 100% until the end of the benefit period ends.	None	None
DIAGNOSTIC AND PREVENTIVE (Deductible Waived)		
Routine Exams (once in six months)	Covered in full	20%
X-rays • Periapical X-rays (as required) • Bitewing X-rays (once in six months) • Full Mouth or Panoramic X-rays (one per 60 months)	Covered in full	20%
Fluoride Treatments (once in six months)	Covered in full	20%
Prophylaxis (once in six months)	Covered in full	20%
Sealants (permanent molars; one per tooth in any 36 month period)	Covered in full	20%
Space Maintainers (one per 24 months, per arch)	Covered in full	20%
Palliative Emergency Treatment (acute condition requiring immediate care)	Covered in full	20%
BASIC SERVICES		
Amalgam and composite fillings	50%	70%
Simple Extractions	50%	70%
MAJOR SERVICES		
Oral Surgery (extraction and oral surgery procedures)	50%	70%
Endodontics (procedures for pulpal therapy and root canal filling)	50%	70%
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	50%	70%
General anesthesia (when provided in connection with a covered procedure)	50%	70%
Major Restorative (crowns, inlays, onlays; one per tooth per five year period)	50%	70%
Prosthodontics • Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures; prosthetic replacement limited to once in five years • Implant surgical placement and removal; implant supported prosthetics, including repair and recementation	50%	70%
ORTHODONTICS		
Pediatric Orthodontic Treatment (medically necessary)	50%	Not covered
ORTHODONTICS LIFETIME MAXIMUM		
Lifetime maximum (medically necessary)	None	N/A

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