Capital BLUE

# BlueCross Dental℠
# Dental PPO Standard 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) | | |
| | **Participating Providers** | **Nonparticipating Providers** |
| **DEDUCTIBLE** | | |
| Per benefit period<br>Deductible waived for diagnostic and preventive. | $50 per member<br>$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 | |
| **DIAGNOSTIC AND PREVENTIVE (Deductible Waived)** | | |
| Routine Exams (two per calendar year) | Covered in full | 20% |
| X-rays<br>• Periapical X-rays (as required)<br>• Bitewing X-rays (two per calendar year)<br>• Full Mouth or Panoramic X-rays (one per 3 years) | Covered in full | 20% |
| Prophylaxis (two per calendar year) | Covered in full | 20% |
| Palliative Emergency Treatment (acute condition requiring immediate care) | Covered in full | 20% |
| **BASIC SERVICES** | | |
| Amalgam and composite fillings | 40% | 60% |
| Simple Extractions | 40% | 60% |
| **MAJOR SERVICES** | | |
| Oral Surgery (extraction and oral surgery procedures) | 70% | 90% |
| Endodontics (procedures for pulpal therapy and root canal filling) | 70% | 90% |
| Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered) | 70% | 90% |
| General anesthesia (when provided in connection with covered oral surgery or periodontal surgery) | 70% | 90% |
| Major Restorative (crowns, inlays, onlays) | 70% | 90% |
| Prosthodontics<br>• 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) | 70% | 90% |

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® or by Capital Advantage Insurance Company®, subsidiary companies of Capital BlueCross. Independent licensees 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) | | |
| | **Participating Providers** | **Nonparticipating Providers** |
| **DEDUCTIBLE** | | |
| Per benefit period<br>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<br>$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<br>• Periapical X-rays (as required)<br>• Bitewing X-rays (once in six months)<br>• 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<br>• 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<br>• 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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