Capital BLUE

BlueCross Dental℠
Dental Select Basic

Adult (Age 19 and over) Highlights	Adult (Age 19 and over) Member Copayments**
NETWORK: BlueCross Dental Select	None
DEDUCTIBLE per benefit period*	
BENEFIT PERIOD PROGRAM MAXIMUM	None
WAITING PERIODS	None
OFFICE VISIT COPAYMENT	$10 per visit
DIAGNOSTIC AND PREVENTIVE	
Routine Exams (two per calendar year)	$0
X-rays • Periapical X-rays (as required) • Bitewing X-rays (two per calendar year) • Panoramic X-ray (one full mouth or panoramic in three years)	 $0 $0 $30
Fluoride Treatments (one per calendar year)	$0
Prophylaxis (two per calendar year; one additional cleaning for expecting mothers or diabetics)	$13 (additional cleaning for expecting mothers or diabetics - $40)
BASIC SERVICES	
Silver Filling (two surface)	$51
Composite Filling (two surface anterior)	$83
Root Canal (molar)	$512
Root Planing and Therapy	$109
Extraction, erupted tooth	$69
Extraction of impacted teeth	$241
MAJOR SERVICES	
Crown (porcelain fused to metal)	$523
Denture (complete upper/lower)	$697
Implant Services	15% off provider's usual and customary fees
ORTHODONTICS (comprehensive treatment)	
Adult Orthodontic Treatment	$3,658

*Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

**Copayments for endodontics, periodontics and oral surgery services (including simple extractions) do not apply when performed by a Select participating specialist. Select participating specialists, if available, have entered into an agreement to provide dental services to members at a 25% reduction from their usual, customary and reasonable (UCR) fees. In Delaware, Select participating specialists will provide a reduction from their UCR that will vary between specialists.

Programs are subject to change. **THIS IS NOT A CONTRACT.** This information highlights ***some*** of the dental benefits available when you visit a Select participating provider and is **NOT** intended to be a complete list or complete description of available services. The benefits set forth on this highlight sheet are subject to the specific benefit exclusions and limitations contained in your Certificate of Coverage. Refer to your Certificate of Coverage for benefit and exclusion details.

Primary care dentist (PCD) selection required from our BlueCross *Dental* Select participating network. PCD referrals are required for specialty care. Services obtained outside of the primary dental office in which enrolled and that are not preauthorized by such office or the Plan (with the exception of out-of-area emergency dental services) are not covered.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in your company's other health benefits coverage.

Paper claim forms for encounters and services rendered may be submitted to the following address: BlueCross Dental; PO Box 1126; Elk Grove Village, IL 60009.

Electronic claim forms for encounters and services rendered may be submitted using Payor ID CBC01.

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BlueCross Dental℠
Dental Select Basic

Pediatric (Under age 19) Highlights	Pediatric (Under age 19) Member Copayments
NETWORK: BlueCross Dental Select	None
DEDUCTIBLE per benefit period*	
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 policy covering two or more children
BENEFIT PERIOD PROGRAM MAXIMUM	None
WAITING PERIODS	None
OFFICE VISIT COPAYMENT	$10 per visit
DIAGNOSTIC AND PREVENTIVE	
Routine Exams (once per six months)	$0
X-rays • Periapical X-rays (as required) • Bitewing X-rays (once per six months) • Panoramic X-ray (one full mouth or panoramic in five years)	 $0 $0 $30
Fluoride Treatments (once per six months)	$0
Prophylaxis (once per six months)	$0
Sealants (to age 18 on permanent molars; one sealant per tooth per 36 months)	$21
Space Maintainers (one per 24 months per arch)	$143 unilateral; $198 bilateral
BASIC SERVICES	
Silver Filling (two surface)	$51
Composite Filling (two surface anterior)	$83
Root Canal (molar)	$512
Root Planing and Therapy	$109
Extraction, erupted tooth	$69
Extraction of impacted teeth	$241
MAJOR SERVICES	
Crown (porcelain fused to metal)	$523
Denture (complete upper/lower)	$697
Implant Services	Copayments vary by covered procedure. Refer to your Certificate of Coverage for details.
ORTHODONTICS (comprehensive treatment)	
Pediatric Orthodontic Treatment (medically necessary)	Copayments apply, but are limited to the Out-of-Pocket Maximum
VALUE ADDED DISCOUNTS **	
Non-Medically Necessary Pediatric Orthodontic Treatment: no waiting period; member discounts do not accumulate toward the Out-of-Pocket Maximum	$3,422 comprehensive treatment

*Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

** Value Added Discounts are not insurance and create no liability for payment by the Plan.

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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.