BlueCross Dental
Issued by
CAPITAL ADVANTAGE INSURANCE COMPANY®
A Capital BlueCross Company

DENTAL
Easton Area School District

HIGHLIGHTS	AMOUNTS COVERED
DEDUCTIBLE	
Per benefit period*	None
BENEFIT PERIOD PROGRAM MAXIMUM	
When the program maximum is reached, the Member pays 100% until the end of the benefit period	$1,500 per member per benefit period
DIAGNOSTIC AND PREVENTIVE	
Routine Exams (oral exams limited to once every 6 months; pregnant women and diabetic members may receive one additional oral exam)	100%
X-rays • Periapical X-rays as required • Bitewing X-rays once every 6 months • Full Mouth and Panoramic X-rays once in three years	100%
Fluoride Treatments (once every 6 months for dependent children to age 19)	100%
Prophylaxis (once every 6 months; pregnant women may receive one additional cleaning)	100%
Sealants (for dependent children to age 15 on permanent first and second molars; one sealant per tooth in any three year period)	Not covered
Space Maintainers (for dependent children to age 16)	100%
Palliative Emergency Treatment (acute condition requiring immediate care)	100%
Consultations	100%
BASIC SERVICES	
Basic Restorative (amalgam “silver” fillings and composite “white” non-molar fillings)	80%
Endodontics (procedures for pulpal therapy and root canal filling)	80%
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	80%
Oral Surgery (extraction and oral surgery procedures, including pre- and post-operative care; general anesthesia is covered when used in conjunction with covered oral surgical procedures)	80%
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	80%
Denture Repair	80%
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	Not covered
ORTHODONTICS	
Orthodontic Treatment (covered for dependent children to age 19; procedure for straightening teeth)	Not covered
ORTHODONTICS LIFETIME MAXIMUM	
Lifetime maximum per dependent	Not applicable

Programs are subject to change. **This is not a contract. This information highlights dental benefits when you visit a participating provider and is not intended to be a complete list or complete description of available services.**

Participating providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider’s charges and the allowable amount.

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

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

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The benefits set forth on this highlight sheet are subject to the specific benefit exclusions and limitations contained in your Certificate of Coverage. Examples of categories of benefit exclusions to coverage include, but are not limited to, the following:

1. Services or supplies which are provided to patient by any federal or state government agency except Medicaid, or by any municipality, county, or other political subdivision;
2. Services that are the responsibility of Worker's Compensation or employer's liability insurance, or for treatment of any automobile-related injury;
3. Charges for which benefits or services are provided to the patient by any hospital, medical or dental service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise);
4. Services provided or supplies furnished or devices started prior to the effective eligibility date of a patient;
5. Treatment or supplies for which the patient would have no legal obligation to pay in the absence of this or any other similar coverage;
6. Treatment or supplies with respect to congenital malformations;
7. Treatment or devices that increase the vertical dimension of an occlusion, restore an occlusion to normal, replace tooth structure lost by attrition or erosion, or otherwise;
8. Preventive plaque control programs, including oral hygiene programs;
9. Fissure sealants unless covered under the group contract;
10. Periodontal splinting, equilibration and gnathological recordings;
11. Myofunctional therapy;
12. Temporomandibular joint dysfunction, unless covered under the group contract;
13. Replacement or repair of lost, stolen, or damaged prosthetic or orthodontic appliances;
14. Prescription drugs, pre-medication, analgesias, and general anesthesia, unless covered under the group contract;
15. Experimental procedures;
16. Treatment or supplies primarily for cosmetic purposes;
17. Elective procedures;
18. Sealants;
19. Prosthodontic services, including bridges, dentures and implants (except denture repair which is covered);
20. Orthodontic services, including tooth guidance appliances;
21. For any other service or treatment, except as provided in the group contract.

The foregoing list highlights categories of dental benefit exclusions and is not intended to be a complete list or complete description of all categories of benefit exclusions. Please contact your employer, marketing representative or broker for additional details concerning benefit exclusions, or you may refer to the Schedule of Exclusions set forth in your Certificate of Coverage.