Capital BLUE

BlueCross Dental[SM]
Tamaqua Area School District

HIGHLIGHTS	Member Cost-Sharing
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	None
DIAGNOSTIC AND PREVENTIVE	
Routine Exams (oral exams limited to once in six months	Covered in full
X-rays • Periapical X-rays as required • Bitewing X-rays once in six months • Full Mouth and Panoramic X-rays once in 36 months	Covered in full
Fluoride Treatments (once in six months for dependent children under age 19)	Covered in full
Prophylaxis (once in six months)	Covered in full
Sealants (for dependent children)	Covered in full
Space Maintainers (for dependent children under age 19)	Covered in full
Palliative Emergency Treatment (acute condition requiring immediate care)	Covered in full
Consultations (Inpatient Only)	Covered in full
BASIC SERVICES	
Basic Restorative (amalgam “silver” fillings and composite “white” fillings)	Covered in full
Endodontics (procedures for pulpal therapy and root canal filling)	Covered in full
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	Not covered
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)	Oral surgery 80%; simple extractions Covered in full; anesthesia Covered in full
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	20%
Denture repair	Covered in full
Veneers on crown or pontics for the ten upper and lower anterior teeth	20%
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.

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 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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Large Group Benefits