Capital Blue Cross Dental
Dental PPO (Low) Voluntary

Capital

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 Certificate of Coverage (COC). Refer to your COC for benefit details.

HIGHLIGHTS	MEMBER COST-SHARING
NETWORK: Capital Blue Cross Dental PPO	
DEDUCTIBLE	
Per benefit period Deductible waived for diagnostic and preventive	$50 per member $150 per family
BENEFIT PERIOD PROGRAM MAXIMUM	
When the program maximum is reached, the Member pays 100% until the end of the benefit period	$1,000 per member per benefit period
DIAGNOSTIC AND PREVENTIVE (Deductible Waived)	
Routine Exams (oral exams limited to twice in twelve months)	Covered in full
X-rays • Periapical X-rays as required • Bitewing X-rays twice in twelve months • Full Mouth or Panoramic X-rays once in three years	20%
Fluoride Treatments (twice in twelve months, to age 19)	Covered in full
Prophylaxis (twice in twelve months)	Covered in full
Sealants (for dependent children to age 16 applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 60 months)	20%
Space Maintainers (for dependent children to age 19)	20%
Palliative Emergency Treatment (acute condition requiring immediate care)	Covered in full
Consultations	Covered in full
BASIC SERVICES	
Basic Restorative (amalgam "silver" fillings and composite "white" fillings)	20%
Endodontics (procedures for pulpal therapy and root canal filling)	20%
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	20%
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)	20%

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 your company's other health benefits coverage.

Paper claims may be submitted to the following address: Dental Claims Processing Center; PO Box 211424; Eagan, MN 55121.

Electronic claims may be submitted using Payor ID CBC01.