Capital BLUE

BlueCross Dental℠
Mifflinburg Area School District

HIGHLIGHTS	Member Cost-Sharing
DEDUCTIBLE	
Deductible applies to all services	$50 per member per lifetime
BENEFIT PERIOD PROGRAM MAXIMUM	
When the program maximum is reached, the Member pays 100% until the end of the benefit period	$500 per member per benefit period
DIAGNOSTIC AND PREVENTIVE	
Routine Exams (oral exams limited to once in six months	Member must have one dental checkup per year and all basic services recommended by the dentist as a result of the initial checkup must be completed during that year. If during any year the member fails to have a dental checkup and all recommended basic services are not performed, payment for future claims will again start at 30 percent.
X-rays • Periapical X-rays as required • Bitewing X-rays as required • Full Mouth and Panoramic X-rays once in 36 months	
Fluoride Treatments (once in six months for dependent children to age 19)	
Prophylaxis (once in six months)	
Space Maintainers (for dependent children to age 19)	
Palliative Emergency Treatment (acute condition requiring immediate care)	Year 1: 30% Year 2: 20% Year 3: 10% After Year 3: 0%
Consultations (Inpatient Only)	
BASIC SERVICES	
Basic Restorative (amalgam “silver” fillings and composite “white” fillings)	
Endodontics (procedures for pulpal therapy and root canal filling)	
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)	
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	
Veneers on crown or pontics for the ten upper and lower anterior teeth	
Prosthodontics • Denture repair	
• Denture replacement	50%

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.

BCDS13
07/2018