Capital Blue Cross Dental
Shikellamy School District

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
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	$2,000 per member per benefit period
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 as required • Full Mouth and Panoramic X-rays once in 36 months	Covered in full
Fluoride Treatments (once in six months for dependent children to age 19)	Covered in full
Prophylaxis (once in six months)	Covered in full
Sealants (for dependent children to age 14 on permanent first and second molars; one sealant per tooth in any three year period	Covered in full
Space Maintainers (for dependent children to 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)	50%
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)	Covered in full
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	50%; crown repair and recements Covered in full
Prosthodontics • Denture/Bridge Repair and Recement (relines, rebase, addition of tooth, and adjustments are not covered) • Denture replacement	 Covered in full 50%
Veneers on crown or pontics for the ten upper and lower anterior teeth	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.

Benefits are issued by Capital Advantage Assurance Company®, a subsidiary company of Capital Blue Cross. Independent licensee of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.