BlueCross Dental℠

DENTAL Plus
Lafayette College

HIGHLIGHTS	Member Cost-Sharing
NETWORK: BlueCross Dental PPO	
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	$1,000 per member per benefit period. A maximum of $500 of unused benefits may be rolled over per benefit period, not to exceed a combined benefit period and rollover program maximum of $2,000 in a benefit period.
DIAGNOSTIC AND PREVENTIVE	
Routine Exams (oral exams limited to twice in twelve months; pregnant women may receive one additional oral exam)	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	Covered in full
Fluoride Treatments (twice in twelve months for dependent children to age 19)	Covered in full
Prophylaxis (twice in twelve months; pregnant women may receive one additional cleaning)	Covered in full
Sealants (for dependent children to age 15 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	Covered in full
BASIC SERVICES	
Basic Restorative (amalgam “silver” fillings and composite “white” non-molar 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%
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	50%
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	50%
ORTHODONTICS	
Orthodontic Treatment (covered for dependent children to age 19; procedure for straightening teeth)	50%
ORTHODONTICS LIFETIME MAXIMUM	
Lifetime maximum per dependent	$1,000

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.