Capital Blue Cross Dental
Northampton Community College

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 Benefits Booklet. Refer to your Booklet for benefit details.

HIGHLIGHTS	Member Cost-Sharing
NETWORK: Capital Blue Cross Dental PPO Preferred	
DEDUCTIBLE	
Per benefit period* **Deductible applies to all services**	$20 per member $60 per family
BENEFIT PERIOD PROGRAM MAXIMUM	
When the program maximum is reached, the Member pays 100% until the end of the benefit period	$1,500 per member per benefit period
DIAGNOSTIC AND PREVENTIVE (Deductible Waived)	
Routine Exams (oral exams limited to once every six months; pregnant women may receive one additional oral exam)	Covered in full
X-rays • 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)	Covered in full
Prophylaxis (once every six months; pregnant women may receive one additional cleaning)	Covered in full
Sealants (for dependent children to age 19 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” fillings)	Covered in full
X-rays (other than those covered under Diagnostic and Preventive)	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)	Covered in full
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
Injectable Antibiotics	Covered in full
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	Covered in full
Prosthodontics (missing tooth clause, onlays) • 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	50% including rebasing or relining
Repair and recementation	Covered in full
ORTHODONTICS (Deductible Waived)	
Orthodontic Treatment (covered for dependent children to age 19; procedure for straightening teeth)	50%
Lifetime maximum per dependent	$1,500

In-Network providers agree to accept our allowance 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.

*Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

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.

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.