



MASSACHUSETTS

## Dental Blue<sup>®</sup> *The right choice*



At Blue Cross Blue Shield of Massachusetts, we are committed to our members' total well-being. Good oral health is an important part of overall health. Enrolling separately in a health plan that meets Massachusetts' Health Care Reform Law's Minimum Creditable Coverage Standards will help ensure that you will receive comprehensive health and dental coverage.

# Dental Blue Select

## (with Orthodontics) A Dental Blue PPO Option

### Summary of Benefits

Effective April 1, 2009



This dental plan, on its own, does not meet Minimum Creditable Coverage Standards for Massachusetts residents that will be effective January 1, 2009, as part of the Massachusetts Health Care Reform Law.

# Dental Blue Select with Orthodontics

Preventive Benefit Group		Basic Benefit Group		Major Benefit Group	
In Network	Full Coverage	In Network	90% Coverage	In Network	60% Coverage
<b>Out-of-Network</b>	<b>Full Coverage</b>	<b>Out-of-Network</b>	<b>80% Coverage</b>	<b>Out-of-Network</b>	<b>50% Coverage</b>
<b>(after a \$25 Per Member/\$75 Per Family Calendar-Year Deductible)</b>					
<b>\$1,000 Calendar-Year Benefit Maximum (network and non-network combined)</b>					
<p><b>Diagnostic</b></p> <ul style="list-style-type: none"> <li>One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures</li> <li>Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months</li> <li>Bitewing X-rays once each six months</li> <li>Single tooth X-rays as needed</li> <li>Study models and casts used in planning treatment once each 60 months</li> <li>Periodic or routine oral exams once each six months</li> <li>Emergency exams</li> </ul> <p><b>Preventive</b></p> <ul style="list-style-type: none"> <li>Routine cleaning, scaling, and polishing of the teeth once each six months</li> <li>Fluoride treatment once each six months (members under age 19)</li> <li>Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per bicuspid or molar surface each 48 months.</li> <li>Space maintainers needed due to premature tooth loss (members under age 19)</li> </ul>		<p><b>Restorative</b></p> <ul style="list-style-type: none"> <li>Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)</li> <li>Composite resin (tooth color) fillings on front teeth (limited to one filling for each tooth surface in a 12-month period)</li> <li>Composite resin fillings on a single-surface back tooth (bicuspid and molars) in a 12-month period. (Benefits will continue to be provided for amalgam fillings toward the cost of multiple surface composite resin fillings. You pay any balance.)</li> <li>Pin retention for fillings</li> <li>Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)</li> </ul> <p><b>Oral Surgery</b></p> <ul style="list-style-type: none"> <li>Tooth extraction</li> <li>Root removal</li> <li>Biopsies</li> </ul> <p><b>Periodontics (gum and bone)</b></p> <ul style="list-style-type: none"> <li>Periodontal scaling and root planing once per quadrant each 24 months</li> <li>Periodontal surgery once per quadrant each 36 months</li> <li>Periodontal maintenance following active periodontal therapy once each three months</li> </ul> <p><b>Endodontics (roots and pulp)</b></p> <ul style="list-style-type: none"> <li>Root canal therapy (permanent teeth, once per lifetime per tooth)</li> <li>Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth</li> <li>Therapeutic pulpotomy on primary or permanent teeth (members under age 16)</li> <li>Other endodontic surgery to treat or remove the dental root</li> </ul> <p><b>Prosthetic Maintenance</b></p> <ul style="list-style-type: none"> <li>Repair of partial or complete dentures, crowns, and bridges once each 12 months</li> <li>Adding teeth to an existing complete or partial denture</li> <li>Rebase or reline of dentures once each 36 months</li> <li>Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months</li> </ul> <p><b>Other Services</b></p> <ul style="list-style-type: none"> <li>Occlusal adjustments once each 24 months</li> <li>Services to treat root sensitivity</li> <li>Emergency dental care to treat acute pain or to prevent permanent harm to a member</li> <li>General anesthesia when administered in conjunction with covered surgical services</li> </ul>		<p><b>Prosthetics (teeth replacement)</b></p> <ul style="list-style-type: none"> <li>Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch</li> <li>Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth</li> <li>Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable</li> <li>Adding teeth to an existing bridge</li> <li>Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)</li> </ul> <p><b>Major Restorative (members age 16 or older)</b></p> <ul style="list-style-type: none"> <li>Crowns, once each 60 months for each tooth</li> <li>Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.</li> <li>Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth</li> <li>Replacement of crowns, once each 60 months for each tooth</li> <li>Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.</li> <li>Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth</li> <li>Post and core or crown buildup, once each 60 months for each tooth</li> <li>Single-tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars (members age 16 and older)</li> </ul>	
<b>Orthodontic Benefit Group</b>					
Full coverage for members up to age 19 No deductible					
Benefits are reduced by 20% when services are received from a non-network dentist.					
<ul style="list-style-type: none"> <li>Complete orthodontic exam</li> <li>Comprehensive or limited active orthodontic treatment, including appliances</li> </ul>					
<b>\$1,500 Lifetime Benefit Maximum</b>					

Welcome to Dental Blue Select, a dental PPO plan designed to manage the cost of dental services. Dental Blue Select offers a wide network of dentists. Dentists who participate with Blue Cross Blue Shield of Rhode Island and the DenteMax Network of Dentists are also part of the Dental Blue PPO Network. Using network dentists will minimize your out-of-pocket expenses.

## Your Dentist

If you already have a dentist and you want to know if he or she participates in the Dental Blue PPO network, you may call the dentist, refer to the most current dental provider directory, or call Member Service at the toll-free telephone number shown on your Dental Blue ID card.

If you would like help choosing a dentist, you may call the Physician Selection Service at **1-800-821-1388**. You may also access the online dental provider directory at [www.bluecrossma.com](http://www.bluecrossma.com).

## Your Benefits

Benefits are subject to the deductible, co-insurance, and benefit maximum amounts chosen by your group. Payments are based on whether or not you receive services from a network or non-network dentist. Please refer to the chart to the left for the amounts your group has chosen for you.

Many covered services have specific time or age limits associated with them. For example:

- Cleanings are provided only once each six months.
- Fluoride treatments are provided only for members under age 19.

## Pre-Treatment Estimates

If your dentist expects that your dental treatment will involve covered services that will cost more than \$250, he or she should send a copy of the “treatment plan” to Blue Cross Blue Shield before services are rendered. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate for the charges for each service.

Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year or lifetime benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year or lifetime benefit maximum or eligibility status has changed.)

## Multi-Stage Procedures

Your dental plan provides benefits for multi-stage procedures (these are procedures that require more than one visit, such as crowns, dentures, and root canals) as long as you are enrolled under the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield for processing only after the completion date of the procedure.

You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

## How Network Dentists Are Paid

Payments are based on the allowed charge for covered services. Network dentists agree to accept the allowed charge as payment in full. You pay only your co-insurance and any charges beyond your calendar-year or lifetime benefit maximum.

## How Non-Network Dentists Are Paid

Payments are based on the usual and customary charge. The usual and customary charge may sometimes be less than the dentist’s actual charge. If this is the case, you must pay the amount of the dentist’s actual charge that is in excess of the dentist’s usual and customary charge. However, if the dentist’s actual charge is less than the usual and customary charge, your benefits will be calculated based on the dentist’s actual charge. You are also responsible for the deductible, co-insurance, and any charges beyond your calendar-year or lifetime benefit maximum.

## How Orthodontic Benefits Are Paid

Your group has purchased orthodontic coverage. The lifetime benefit maximum is not part of your calendar-year benefit maximum; it applies only to orthodontic services. You are responsible for your co-insurance (if applicable) and any charges beyond your lifetime benefit maximum, up to the allowed charge.

Your non-network orthodontic benefits are provided at 80 percent of the network benefit level and calculated using the dentist’s actual charges. You are responsible for the difference between the Blue Cross Blue Shield payment and the dentist’s actual charge and any charges beyond your lifetime benefit maximum.

Benefits are available on your effective date. If your orthodontic treatment began before you were covered under Dental Blue, a monthly fee will be paid for your remaining orthodontic visits until either your treatment is completed or the lifetime benefit maximum is exhausted, whichever comes first.

## When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan.

## Dependent Benefits

This plan covers dependents up to age 26, or for two years after the end of the calendar year in which they last qualified as a dependent under the Internal Revenue Code, whichever comes first. Additionally, this plan may cover unmarried full-time students or other unmarried dependents who do not otherwise qualify as eligible dependents. Please see your plan description (and riders, if any) for exact coverage details.

## If You Have to File a Claim

Network dentists will send claims to Blue Cross Blue Shield for you. Just show them your Dental Blue ID card. The payment will be sent directly to your dentist when claims are received within one year of the completed service.

If you receive care from a non-network dentist, you may have to submit the claim yourself. If you file, send the Attending Dentist's Statement with the original itemized bills. Any benefit payment will be sent to you. You can get Attending Dentist's Statements from Member Service.

Any claims that you file should be sent to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298.

All member-submitted claims must be submitted within two years of the date of service.

The Blue Cross Blue Shield Grievance Program is fully described in the plan description.

## Other Information

Coordination of benefits, or COB, applies to plan members who are covered by another plan for health care expenses. COB ensures that payments from all health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause. This does not affect the scope of benefits. It allows claim payments to be retracted when a member recovers payment for the same charges from a third party due to liability for injury.

## Enhanced Dental Benefits

Enhanced Dental Benefits for certain dental care services are available if you are a member who has been diagnosed with either diabetes, coronary artery disease, or you are a member who is pregnant. Contact Member Service for more information.

## Accumulated Maximum Rollover Benefits

This dental plan includes an Accumulated Maximum Rollover Benefit. This rollover benefit allows members to roll over a certain portion of their unused annual dental benefits so that they can use them in a future year. There are limits and restrictions on this benefit. Refer to the Dental Maximum Rollover brochure for further information.

## Questions? Call 1-800-262-BLUE (2583).

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at [www.bluecrossma.com](http://www.bluecrossma.com).

**Limitations and Exclusions.** These pages summarize your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.





## Maximum Rollover

At Blue Cross Blue Shield of Massachusetts, we understand that oral health is a critical part of over all health. That's why we're introducing a new dental benefit that will allow you to roll over a portion of your unused dental benefits from year to year.

This means that, beginning in 2009, you can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures.

This benefit applies to you automatically if you:

- Receive at least one service during the benefit period
- Remain a member of the plan for the entire benefit period
- Do not exceed the claim payment threshold in the benefit period

## How Maximum Rollover Works

Beginning 60 days after the last day of your benefit period, your rollover amount will be added to your maximum benefit amount, increasing it for you to use that year and beyond (see below for amounts and maximums).

There is no cost to you. You don't need to do anything. In order to figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross Blue Shield of Massachusetts does not pay out more claims dollars on your behalf than the amount in the 2nd column, your benefit maximum for the next year will increase by the amount in the 3rd column.

And, your rollover amount keeps growing and is available for you to use as long as your employer offers this rollover benefit.\* The last column will show you the total amount of additional benefit dollars you can earn. It's one more way Blue Cross Blue Shield of Massachusetts is striving to improve health care for all our members.

If your dental plan's annual maximum benefit amount is:	And if your total claims don't exceed this amount for the benefit period:*	Then we will roll over this amount for you to use next year and beyond:*	However, rollover totals will be capped at this amount:*
\$500–\$749	\$200	\$150	\$500
\$750–\$999	\$300	\$200	\$500
\$1,000–\$1,249	\$500	\$350	\$1,000
\$1,250–\$1,499	\$600	\$450	\$1,250
\$1,500–\$1,999	\$700	\$500	\$1,250
\$2,000–\$2,499	\$800	\$600	\$1,500
\$2,500–\$2,999	\$900	\$700	\$1,500
\$3,000 or more	\$1,000	\$750	\$1,500

\*This is not an FSA. The amount reflects your benefit maximum for a given year.