Dental Blue®
The right choice

Dental Blue PPO Program 2 (Effective 1/1/06)

Preventive Benefit Group

No Deductible

_____Coverage

Coverage reduced by 20% when services are received from a non-network provider.

Diagnostic

- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- Bitewing X-rays once each six months
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams once each six months
- Emergency exams

Preventive

- Routine cleaning, scaling, and polishing of the teeth once each six months
- Fluoride treatment (members under age 19) once each six months
- Sealants on permanent pre-molar and molar surfaces (members under age 14), one application per premolar or molar surface each 48 months
- Space maintainers needed due to premature tooth loss (members under age 19)

Basic Benefit Group

$_____Per Member/$_____Per Family

Calendar-Year Deductible

_____Coverage

Coverage reduced by 20% when services are received from a non-network provider.

Restorative

- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings on front teeth (limited to one filling for each tooth surface in a 12-month period). Benefits are provided for amalgam fillings towards the cost of composite resin (tooth color) fillings on back teeth (bicuspids and molars). You pay any balance
- Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery

- Tooth extraction
- Root removal
- Biopsies

Periodontics (gum and bone)

- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)

- Root canal therapy on permanent teeth, once in a lifetime for each tooth
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- Other endodontic surgery intended to treat or remove dental root

Prosthetic Maintenance

- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- Adding teeth to an existing complete or partial denture
- Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Covered Services

- Occlusal adjustments once each 24 months
- Services to treat root sensitivity
- Emergency dental care to treat acute pain or to prevent permanent harm to a member
- General anesthesia when administered in conjunction with covered surgical services

Major Benefit Group

_____Coverage

Coverage reduced by 20% when services are received from a non-network provider.

Prosthodontics (teeth replacement)

- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- Adding teeth to an existing bridge
- 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)

Major Restorative (members age 16 or older)

- Crowns, once each 60 months for each tooth
- 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
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- 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
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Post and core or crown buildup, once each 60 months for each tooth

Optional Orthodontic Benefit Coverage

No deductible _____Coverage

Coverage reduced by 20% when services are received from a non-network provider.

___All members ___Members to age 19

- Complete orthodontic exam
- Comprehensive or limited active orthodontic treatment including appliances

$_____Lifetime Benefit Maximum

$_____Calendar-Year Benefit Maximum

Monthly Premiums

Dental Blue PPO Program 2

Individual Membership $_____

Individual + 1 Membership $_____

Family Membership $_____

Dental Blue PPO Program 2 with Orthodontic Benefits

Individual Membership $_____

Individual + 1 Membership $_____

Family Membership $_____

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Blue Cross BlueShield of Massachusetts