Dental Blue
Pediatric Essential Benefits
Summary of Benefits
For Members Under Age 19

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association
## Dental Blue Pediatric Essential Benefits

<table>
<thead>
<tr>
<th>Preventive Benefit Group*</th>
<th>Basic Benefit Group*</th>
<th>Major Benefit Group*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Deductible</strong></td>
<td><strong>$50 Per Member Plan-Year Deductible</strong></td>
<td><strong>$50 Per Member Plan-Year Deductible</strong></td>
</tr>
<tr>
<td></td>
<td>(No more than $150 for three or more members under age 19 enrolled under the same family membership)</td>
<td>(No more than $150 for three or more members under age 19 enrolled under the same family membership)</td>
</tr>
<tr>
<td><strong>Full Coverage</strong></td>
<td><strong>75% Coverage</strong></td>
<td><strong>50% Coverage</strong></td>
</tr>
<tr>
<td><strong>$350 Per Member (No more than $700 for two or more members under age 19 enrolled under the same family membership)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Plan-Year Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Oral Exams
- One complete initial oral exam per provider or location (including initial history and charting of teeth and supporting structures)
- Periodic or routine oral exams; twice in 12 months
- Oral exams for a member under age three; twice in 12 months
- Limited oral exams; twice in 12 months

### X-rays
- Single tooth X-rays; no more than one per visit
- Bitewing X-rays; twice in 12 months
- Full mouth X-rays; once in 36 months per provider or location
- Panoramic X-rays; once in 36 months per provider or location

### Routine Dental Care
- Routine cleaning, minor scaling, and polishing of the teeth; twice in 12 months
- Fluoride treatments; once per calendar quarter
- Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered)
- Space maintainers

### Fillings
- Amalgam (silver) fillings; one filling per tooth surface in 12 months
- Composite resin (white) fillings; one filling per tooth surface in 12 months (for primary, back teeth; payment for a composite filling will not be more than the amount allowed for an amalgam filling)

### Root Canal (treatment for permanent teeth only)
- Root canals on permanent teeth; once per tooth
- Vital pulpotomy
- Retreatment of prior root canal on permanent teeth; once per tooth in 24 months
- Root end surgery on permanent teeth; once per tooth

### Crowns
- Prefabricated stainless steel crowns; once per tooth (primary and permanent)

### Gum Treatment
- Periodontal scaling and root planing; once per quadrant in 36 months
- Gingivectomy; once per quadrant in 36 months

### Prosthetic Maintenance
- Repair of partial or complete dentures and bridges; once in 12 months
- Reline or rebase partial or complete dentures; once in 24 months

### Oral Surgery
- Simple tooth extractions; once per tooth
- Erupted or exposed root removal; once per tooth
- Surgical extractions; once per tooth (approval required for complete, bony impactions)
- Other necessary oral surgery

### Other Necessary Services
- Dental care to relieve pain (palliative care)
- General anesthesia for covered oral surgery

### Orthodontic Benefit Group*  

<table>
<thead>
<tr>
<th>No Deductible</th>
<th></th>
</tr>
</thead>
</table>

Coverage is only provided for medically necessary orthodontic care and requires prior authorization before services are provided.

After prior authorization, you have:
- **50% coverage**
  - Braces for a member who has a severe and handicapping malocclusion
  - Related orthodontic services for a member who qualifies

* In Massachusetts, benefits are only provided when covered services are furnished by a participating dentist.
Welcome to Dental Blue, a comprehensive dental plan that provides a wide range of benefits to meet a variety of your dental care needs.

Your Dentist
Dental Blue offers an extensive network of dentists. Over 90% of dentists in Massachusetts and New Hampshire participate with Blue Cross Blue Shield of Massachusetts. Dentists who participate with Blue Cross Blue Shield of Rhode Island and out-of-area dentists who participate in the DenteMax Network of Dentists are also available to Dental Blue members.

If you already have a dentist and you want to know if he or she is participating with Blue Cross Blue Shield of Massachusetts, 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.

Your Benefits
Benefits are subject to the deductible and co-insurance (if applicable). Please refer to the chart to the left for your cost share amounts.

Many of the covered services have specific time limits or age limits associated with them. For example:
- Cleanings are provided only twice in 12 months.
- Fluoride treatments are provided once per calendar quarter.

Out-of-Pocket Maximum
This plan includes an out-of-pocket maximum of $350 per member (no more than $700 for two or more members under age 19 enrolled under the same family membership). The money paid for the deductible and co-insurance is included in calculating the out-of-pocket maximum. The out-of-pocket maximum is the most you could pay during a plan year for your share of costs for covered services. Even though you pay the following costs, they do not count toward your out-of-pocket maximum: your premiums; any balance-billed charges; all costs for dental services for members age 19 or older; and all services this Dental Blue policy does not cover.

Pre-Treatment Estimates and Prior Authorizations
If your dentist expects that your dental treatment will involve covered services that will cost more than $250, he or she must 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 for those services.

If your dentist has determined you will need a service that has been identified as needing prior authorization, he or she must request approval for those services to be covered prior to the services being rendered.

Prior authorization services rendered without obtaining a prior authorization approval may not be covered by this plan.

You will be responsible for all charges for services not approved through the prior approval process or rendered without prior authorization.

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 Dentists Are Paid
Participating Dentists
Dentists that participate with Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Rhode Island, or out-of-area dentists that are in the DenteMax Network of Dentists, accept the lesser of either the dentist’s actual charge or the allowed charge as payment in full for covered services. You pay only your deductible and co-insurance (if applicable).

In Massachusetts, benefits are only provided when covered services are furnished by a participating dentist.

Dentists Outside of Massachusetts
Benefits for covered services by a dentist outside of Massachusetts are provided based on the dentist’s actual charge or the allowed charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist’s actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and co-insurance (if applicable).

How Orthodontic Benefits Are Paid
Orthodontic benefits are available on or after your effective date. Coverage is only provided for medically necessary orthodontic services and requires prior authorization before services are provided. Orthodontic benefits are calculated using the allowed charge. You may be responsible for the deductible, co-insurance (if applicable), and any difference between the Blue Cross Blue Shield payment and the dentist’s actual charge. Please see your plan description (and riders, if any) for exact coverage details.
When Coverage Begins
You are covered, without a waiting period, from the date you enroll in the plan.

If You Have to File a Claim
Participating dentists will send claims to Blue Cross Blue Shield for you. Just show them your Blue Cross Blue Shield of Massachusetts Medical 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 emergency care in Massachusetts by a non-participating dentist because a participating dentist was not available, you or the dentist may file an Attending Dentist’s Statement. 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.

Questions? Call The Commonwealth Health Connector at 1-877-MA-ENROLL.
You can also visit www.mahealthconnector.org or www.bluecrossma.com/getblue for more information.

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.