MASSACHUSETTS | Dental Blue® The right choice

Dental Blue® Pediatric + Adult 2

Pediatric Essential Dental Benefits

Your Benefits
The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and out-of-pocket maximum amounts shown below. The calendar year begins on January 1 and ends on December 31 of each year. The chart below shows the percentage of costs your plan will pay for covered dental services. Many covered services have specific time limits.

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most you could pay during a calendar year for deductible and coinsurance for covered services in this portion of the plan. The out-of-pocket maximum is **$350** per member (or **$700** for two or more members). Costs that do not count towards your out-of-pocket maximum are premiums, any balance-billed charges, all dental services for members who are not eligible for pediatric essential dental benefits, and all services that this policy does not cover.

When Coverage Begins
You are covered, without a waiting period, from the date you enroll in the plan. Dental benefits in this portion of the plan are provided for members until the end of the calendar month in which they turn age 19.

Orthodontic Benefits
Orthodontic benefits are available on or after your effective date. Coverage is provided for medically necessary orthodontic care and requires prior authorization before services are provided. If you do not qualify for medically necessary orthodontic care, additional orthodontic benefits may be available. Orthodontic benefits are calculated using the allowed charge for the orthodontic procedure. You may be responsible for the coinsurance (if applicable), and any difference between the Blue Cross Blue Shield payment and the dentist's actual charge. If any additional orthodontic treatment began before you were covered under Dental Blue, a monthly fee will be paid for your remaining orthodontic visits until your treatment is completed or you have reached your lifetime benefit maximum, whichever applies. See your plan description (and riders, if any) for exact coverage details.

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
Full Coverage	**80% Coverage**	**50% Coverage**
No Deductible	**$50 Per Member/$150 Per Family Calendar-Year Deductible**	
$350 Per Member ($700 for Two or More Members) Calendar-Year Out-of-Pocket Maximum		

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

X-rays
- Single tooth X-rays, as needed
- Bitewing X-rays; twice in a calendar year
- Full mouth X-rays; once in three calendar years per provider or location
- Panoramic X-rays; once in three calendar years per provider or location

Routine Dental Care
- Routine cleaning, minor scaling, and polishing of the teeth; twice in a calendar year
- Fluoride treatments; once in 90 days
- 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

Root Canal Treatment
- 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 24 months
- Periodontal surgery; 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
- Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth

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, boney impactions)
- Other necessary oral surgery

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

Crowns
- Resin crowns; once per tooth in 60 months
- Porcelain/ceramic crowns; once per tooth in 60 months
- Porcelain fused to metal/high noble crowns; once per tooth in 60 months

Tooth Replacement
- Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months
- Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months

Implants
- Single tooth dental endosteal implants for members age 16 and older when the implant replaces permanent teeth through second molars; once per tooth in 60 months

Other Necessary Services
- Occlusal guards when necessary; once in a calendar year
- Fabrication of an athletic mouth guard

Medically Necessary Orthodontics*
50% coverage after prior authorization
No deductible
- Braces for a member who has a severe and handicapping malocclusion
- Related orthodontic services for a member who qualifies

Additional Orthodontics may be available**
Full coverage
No deductible
- Complete orthodontic exam
- Comprehensive or limited active orthodontic treatment, including appliances

Lifetime Benefit Maximum Applies

* Medically Necessary Orthodontics are considered Essential Health Benefits (EHBs) and require prior authorization before services are provided. The $350 per member ($700 for two or more members) calendar-year out-of-pocket maximum applies.

** Refer to your Renewal Rate Exhibit to determine coverage availability and lifetime maximum. See your plan description and riders for exact coverage details.

Dental Benefits for Members Age 19 and Older

Your Benefits

The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and benefit maximum amounts shown below. The calendar year begins on January 1 and ends on December 31 of each year. The chart below shows the percentage of costs your plan will pay for covered dental services. Many covered services have specific time limits.

Your Benefit Maximum

Your benefit maximum is the most your plan will pay for covered services during a calendar year in this portion of the plan. Once your plan has paid the benefit maximum of **$2,000** per member, no additional dental benefits will be provided during that calendar year. When this happens, you must pay the allowed charge for any services you receive for the rest of the calendar year.

When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan. Dental benefits in this portion of the plan are provided for members who are age 19 and older and who are not eligible for pediatric essential dental benefits.

Accumulated Maximum Rollover Benefits

This portion of the dental plan includes an Accumulated Maximum Rollover Benefit. This rollover benefit allows you to roll over a certain dollar amount of your unused annual dental benefits for use in the future. There are limits and restrictions on this benefit. Refer to the Accumulated Dental Maximum Rollover brochure for further information.

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
Full Coverage	**80% Coverage**	**50% Coverage**
No Deductible	**$50 Per Member/$150 Per Family Calendar-Year Deductible**	
$2,000 Per Member Calendar-Year Benefit Maximum		

Oral Exams

- Complete initial oral exam (includes initial history and charting of teeth and supporting structures); once in 60 months per provider or location
- Periodic or routine oral exams; twice in a calendar year
- Limited oral exams; twice in a calendar year

X-rays

- Single tooth X-rays, as needed
- Bitewing X-rays; once in 6 months
- Full mouth X-rays; once in 60 months per provider or location
- Panoramic X-rays; once in 60 months per provider or location

Routine Dental Care

- Routine cleaning, scaling, and polishing of the teeth; twice in a calendar year
- Periodontal cleanings; once every 3 months after active periodontal treatment, not to exceed twice in 12 months if combined with routine cleanings

Fillings

- Amalgam (silver) fillings; one filling per tooth surface in 12 months
- Composite resin (white) fillings; one filling per tooth surface in 12 months
- Temporary fillings; one filling per tooth

Root Canal Treatment

- 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

Gum Treatment

- Periodontal scaling and root planing; once per quadrant in 24 months
- Periodontal surgery; 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 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth

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, boney impactions)
- Other necessary oral surgery

Other Necessary Services

- Dental care to relieve pain (palliative care)
- General anesthesia for covered oral surgery

Crowns

- Crowns; once per tooth in 60 months
- Replacement of crowns; once in 60 months
- Metallic, porcelain, and composite resin inlays or onlays; once per tooth in 60 months
- Replacement of metallic, porcelain, or composite resin inlays or onlays; once per tooth in 60 months
- Post and core buildup in addition to crown

Tooth Replacement

- Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months
- Fixed bridges and crowns (when part of a bridge), including services to fabricate, measure, fit, and adjust them; once per tooth in 60 months
- Replacement of denture and bridges, but only when they are installed at least 60 months after the initial placement and only if the existing appliance cannot be made serviceable
- Temporary partial dentures to replace any of the six upper or lower front teeth, but only if they are installed immediately after the loss of teeth and during the period of healing

Implants

- Single tooth dental endosteal implants when the implant replaces permanent teeth through second molars; once per tooth in 60 months

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-800-262-BLUE (2583)**, or visit us online at **bluecrossma.com**. Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at **bluecrossma.com/myblue**.

Limitations and Exclusions. These pages summarize the benefits of 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.

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Accumulated Maximum Rollover

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

This means that 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 throughout the 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.

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Nondiscrimination Notice

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

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Translation Resources
Proficiency of Language Assistance Services

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

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