

Capital Blue Cross Dental

Dental Core

Weis Markets



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	\$50 per member
Deductible waived for diagnostic and preventive, and orthodontic treatment	\$150 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 & Preventive is excluded from the program maximum	
DIAGNOSTIC AND PREVENTIVE	
Routine Exams (oral exams limited to two per calendar year)	50% coinsurance after Deductible
X-rays	50% coinsurance after Deductible
- Periapical X-rays as required - Bitewing X-rays twice in twelve months - Full Mouth or Panoramic X-rays once in three years	
Fluoride Treatments (twice in twelve months)	No charge
Prophylaxis (twice in twelve months)	No charge
Sealants (for dependent children to age 19 on permanent first and second molars; one sealant per tooth in any three year period)	50% coinsurance after Deductible
Space Maintainers (for dependent children to age 19)	No charge
Palliative Emergency Treatment (acute condition requiring immediate care)	50% coinsurance after Deductible
Consultations	No charge
BASIC SERVICES	
Basic Restorative (amalgam "silver" fillings and composite "white" fillings)	50% coinsurance after Deductible
Endodontics (procedures for pulpal therapy and root canal filling)	50% coinsurance after Deductible
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	50% coinsurance after Deductible
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)	50% coinsurance after Deductible
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	50% coinsurance after Deductible
Prosthodontics	50% coinsurance after Deductible
- 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 - Implant surgical placement and removal; implant supported prosthetics, including repair and recementation	
ORTHODONTICS	
Orthodontic Treatment (covered for dependent children to age 19; procedure for straightening teeth)	50% coinsurance
Lifetime maximum per dependent	\$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.

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 of Capital Blue Cross. Independent licensees 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.