MASSACHUSETTS

MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

SUMMARY OF BENEFITS

DENTAL BLUE®
ENHANCED VALUE
(WITH ORTHODONTICS)

MIIA Town of Berkley

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

Download the app, or create an account at **bluecrossma.org.**

DENTAL BLUE ENHANCED VALUE WITH ORTHODONTICS

For members under age 13, benefits (except for orthodontic services) are covered in full up to the calendar-year benefit maximum.

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible		
Full Coverage	Benefits Provided Through a Table of Allowance*	
$1,500 Per Member Calendar-Year Benefit Maximum		

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 twice per calendar year
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams twice per calendar year
- Emergency exams

Preventive
- Routine cleaning, scaling, and polishing of the teeth twice per calendar year
- Fluoride treatment twice per calendar year (members under age 19)
- 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.
- Space maintainers needed due to premature tooth loss (members under age 19)

Restorative
- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period)
- 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 (permanent teeth, once in a lifetime per 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 to treat or remove the 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 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

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

Implants (members age 16 or older)
- 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

Orthodontic Benefit Group

50% coverage for members up to age 19
No deductible
- Complete orthodontic exam
- Comprehensive or limited active orthodontic treatment, including appliances

$1,000 Lifetime Benefit Maximum

* The Table of Allowance (see attachment) lists specific dollar amounts allowed for covered dental procedures. When you see a participating dentist, you're responsible for the difference between the dentist's contracted fee and the amount covered by your plan.

WELCOME TO DENTAL BLUE,

A COMPREHENSIVE DENTAL PLAN PROVIDING BROAD NETWORK ACCESS TO MEET YOUR DENTAL CARE NEEDS.

Your Dentist
Dental Blue offers a large network of dentists, including participating dentists in Massachusetts and nationwide.

If you would like help choosing a dentist, or already have a dentist and want to know if they participate with your plan, you can call the dentist, look at the current dental provider directory, or call Member Service at the toll-free phone number shown on your Dental Blue ID card. You can also access the online dental provider directory at **bluecrossma.org**.

Your Benefits
Your dental plan provides coverage for services listed in the chart and/or on the Table of Allowance. When you receive services from a participating dentist, we will provide payment up to the Table of Allowance amount. You will be responsible for the difference between the Table of Allowance payment and your dentist's contracted rate. The dental benefits your plan covers are subject to the calendar-year benefit maximum amount shown in the chart. **For members under age 13, these benefits (not including orthodontic services) are covered in full up until the calendar-year benefit maximum.** The calendar year begins on January 1 and ends on December 31 of each year. Many of the covered services have specific time or age limits.

Pre-Treatment Estimates
If your dentist expects that your dental treatment will involve covered services that will cost more than $250, Blue Cross Blue Shield recommends that your dentist send a copy of the "treatment plan" to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge 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 (procedures that require more than one visit, such as crowns, dentures and root canals) as long as you are enrolled in 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 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
For Group 1 (Preventive Benefit Group), benefits for covered services by participating dentists with Blue Cross Blue Shield of Massachusetts or nationwide are provided based on the contracted rate that is in effect at the time the covered dental service is provided. This contracted rate is referred to as the dentist's allowed charge.

For Group 2 and Group 3 (Basic and Major Benefit Groups), benefits for covered services by participating dentists in Massachusetts and nationwide are provided based on a Table of Allowance. The Table of Allowance is selected by Blue Cross Blue Shield and includes a specific dollar amount allowance for each covered dental procedure. Blue Cross Blue Shield calculates your benefits based on the Table of Allowance that is in effect at the time the covered dental service is provided. This Table of Allowance amount may sometimes be less than the dentist's contracted rate. If this is the case, you must pay the amount of the dentist's allowed charge that is in excess of the Table of Allowance amount. You are also responsible for any allowed charges beyond your coinsurance (if applicable) and calendar-year or lifetime benefit maximum.

In Massachusetts, benefits are usually only provided when covered services are received from a participating dentist. The exceptions are described in your plan description.

How Dentists Are Paid – Non-participating Dentists Outside of Massachusetts
For Group 1 (Preventive Benefit Group), benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on the allowed charge or the dentist's actual charge, whichever is less. You may be responsible for any balance between the allowed charge and the dentist's actual charge. You are also responsible for the charges beyond your coinsurance (if applicable) and calendar-year or lifetime benefit maximum.

For Group 2 and Group 3 (Basic and Major Benefit Groups), benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on the Table of Allowance that is in effect at the time the covered dental service is furnished. This amount may sometimes be less than the dentist's actual charge. You may be responsible for any balance between the allowed charge and the dentist's actual charge. You are also responsible for the charges beyond your coinsurance (if applicable) and calendar-year or lifetime benefit maximum.

How Orthodontic Benefits Are Paid
Your plan includes 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 coinsurance 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.

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.

Supplemental Coverage – Non-participating Dentists Inside of Massachusetts
Your plan includes supplemental coverage to provide benefits for covered services received in Massachusetts from non-participating dentists.

For Group 1 (Preventive Benefit Group), benefits for covered services by a non-participating dentist inside of Massachusetts are provided based on the maximum allowance or the dentist's actual charge, whichever is less. You may be responsible for any balance between the allowed charge and the dentist's actual charge.

For Group 2 and Group 3 (Basic and Major Benefit Groups), benefits for covered services by a non-participating dentist inside of Massachusetts are provided based on the Table of Allowance or the dentist's actual charge, whichever is less. You may be responsible for any balance between the Table of Allowance amount and the dentist's actual charge.

You are also responsible for the charges beyond your coinsurance (if applicable) and calendar-year or lifetime benefit maximum. See your plan sponsor for details and claim filing information.

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

Dependent Benefits
This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your plan description (and riders, if any) for exact coverage details.

Accumulated Maximum Rollover Benefits
This 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.

Enhanced Dental Benefits
Enhanced Dental Benefits for certain dental care services are available for members who have been diagnosed with qualifying conditions. To learn more about specific conditions included in this benefit, review your plan description (and riders, if any) on MyBlue at **bluecrossma.org**.

If You Have to File a Claim
Participating dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist as long as the claims are received within one year of the completed service.

If you receive care from a non-participating dentist, you will typically need to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service.

After your dentist fills out the form, send it and your original itemized bills 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.

If you have a grievance, see your plan description for instructions on how to file a grievance.

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

Your plan description has a subrogation clause, which means that Blue Cross Blue Shield can recover payments if a member has already been paid for the same claim by a third party.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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MASSACHUSETTS

DENTAL BLUE® ENHANCED VALUE

Thank you for choosing Dental Blue Enhanced Value. With your new plan, all diagnostic and preventive services are covered at no cost to you (100% coverage). You'll receive coverage for other allowed dental services up to a pre-determined dollar amount. When you see an in-network dentist, you're responsible for the difference between the dentist's contracted fee and the amount covered by your plan. The Table of Allowance on page 2 lists the specific dollar amounts we'll pay for covered dental procedures.

When You See an In-Network Dentist

Dentists who participate in the Dental Blue network typically accept contracted fees for their services, which lowers the cost. That means your out-of-pocket costs could be lower when you see an in-network dentist.

When You See an Out-of-Network Dentist

If you visit a dentist who doesn't participate in our network, you'll likely pay significantly more out of pocket. Coverage depends on the type of service you receive:

For Preventive and Diagnostic Services: You're covered up to our standard out-of-network allowances.*

For Basic and Major Restorative Services: You're covered at the Table of Allowance amount or the provider's charge, whichever is lower.

Example of How It Works**

This chart shows how your costs may vary when receiving basic and major restorative services, in network and out of network.

	In-Network Dentist	Out-of-Network Dentist
Cost of Service	$80	$80
Contracted Fee for In-Network Dentists	$63	N/A
Covered Amount, Table of Allowance	$59	$59
Your Final Cost	**$4**	**$21**

How to Find an In-Network Dentist

To find an in-network dentist, visit our Find a Doctor tool at **bluecrossma.com/findadoctor**.

Questions?

If you have any questions, call the Member Service number on your ID card.

* For preventive and diagnostic services, standard out-of-network allowances in Massachusetts are paid at 80% of our contracted provider fee schedule. Coverage for services received outside of Massachusetts is determined based on the usual where the service was received.

** For illustrative purposes only. Dollar amount will vary based on plan and covered service.

TABLE OF ALLOWANCE†

Pre-Treatment Estimates

If your dentist expects that your dental treatment will involve covered services that cost more than $250, we recommend that your dentist should send a copy of the treatment plan to us before services are provided. After we review the treatment plan, 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 benefit maximum at the time the estimate is received and reviewed.

Diagnostic Services

D0120	Periodic Oral Evaluation	100% Coverage
D0140	Limited Oral Evaluation	100% Coverage
D0145	Oral Eval Under 3 Yrs of Age	100% Coverage
D0150	Comprehensive Oral Eval	100% Coverage
D0180	Comprehensive Perio Eval	100% Coverage
D0210	Intraoral - Comprehensive Series of Images	100% Coverage
D0220	Intraoral - Periapical First Film	100% Coverage
D0230	Intraoral - Periapical Adtnl Film	100% Coverage
D0240	Intraoral - Occlusal Film	100% Coverage
D0270	Bitewing - 1 Film	100% Coverage
D0272	Bitewings - 2 Films	100% Coverage
D0273	Bitewings - 3 Films	100% Coverage
D0274	Bitewings - 4 Films	100% Coverage
D0277	Vertical Bitewings - 7 to 8 Films	100% Coverage
D0330	Panoramic Film	100% Coverage

Preventive Services

D1110	Prophylaxis - Adult	100% Coverage
D1120	Prophylaxis - Child	100% Coverage
D1206	Topical Fluoride Varnish	100% Coverage
D1208	Topical Fluoride w/o Varnish	100% Coverage
D1351	Sealant - Per Tooth	100% Coverage
D1352	Preventive Resin Restoration	100% Coverage
D1354	Application of Caries Medicament	100% Coverage
D1510	Space Maintainer - Fixed Unilateral Per Quad	100% Coverage
D1516	Space Maintainer - Fixed Bilateral, Max	100% Coverage
D1517	Space Maintainer - Fixed Bilateral, Man	100% Coverage
D1520	Space Maintainer - Removable Uni-Per Quad	100% Coverage
D1526	Space Maintainer - Removable Bilateral, Max	100% Coverage
D1527	Space Maintainer - Removable Bilateral, Man	100% Coverage
D1551	Recement/Rebond Space Maintainer, Max	100% Coverage
D1552	Recement/Rebond Space Maintainer, Man	100% Coverage
D1553	Recement/Rebond Space Maintainer Per Quad	100% Coverage
D1575	Distal Shoe Space Mntr - Fixed Uni-Per Quad	100% Coverage

Minor Restorative Services

D2140	Amalgam - 1 Surface Prim/Perm	$52
D2150	Amalgam - 2 Surfaces Prim/Perm	$67
D2160	Amalgam - 3 Surfaces Prim/Perm	$79
D2161	Amalgam - 4+ Surfaces Prim/Perm	$94
D2330	Resin-Based Compst 1 Surface Anterior	$63
D2331	Resin-Based Compst 2 Surfaces Anterior	$79

Minor Restorative Services (cont.)

D2332	Resin-Based Compst 3 Surfaces Anterior	$95
D2335	Resin-Based Compst 4+ Surfaces Anterior	$121
D2391	Resin-Based Compst 1 Surface Posterior	$68
D2392	Resin-Based Compst 2 Surfaces Posterior	$98
D2393	Resin-Based Compst 3 Surfaces Posterior	$115
D2394	Resin-Based Compst 4+ Surfaces Posterior	$135

Major Restorative Services

D2542	Onlay – Metallic 2 Surfaces	$245
D2543	Onlay – Metallic 3 Surfaces	$324
D2544	Onlay – Metallic 4+ Surfaces	$336
D2642	Onlay – Porcelain/Ceramic 2 Surfaces	$420
D2643	Onlay – Porcelain/Ceramic 3 Surfaces	$467
D2644	Onlay – Porcelain/Ceramic 4+ Surfaces	$531
D2662	Onlay – Resin-Based Compst 2 Surfaces	$345
D2663	Onlay – Resin-Based Compst 3 Surfaces	$390
D2664	Onlay – Resin-Based Compst 4+ Surfaces	$497
D2710	Crown – Resin-Based Compst Indirect	$125
D2712	Crown – 3/4 Resin-Based Compst Indirect	$108
D2720	Crown – Resin with High Noble Metal	$267
D2721	Crown – Resin with Predmntly Base Metal	$236
D2722	Crown – Resin with Noble Metal	$237
D2740	Crown – Porcelain/Ceramic Substrate	$348
D2750	Crown – Porcelain Fused to High Noble Metal	$345
D2751	Crown – Porcelain Fused to Predmntly Base Metal	$291
D2752	Crown – Porcelain Fused to Noble Metal	$319
D2753	Crown – Porcelain Fused to Titanium	$345
D2780	Crown – 3/4 Cast High Noble Metal	$360
D2781	Crown – 3/4 Cast Predmntly Base Metal	$330
D2782	Crown – 3/4 Cast Noble Metal	$330
D2783	Crown – 3/4 Porcelain/Ceramic	$326
D2790	Crown – Full Cast High Noble Metal	$341
D2791	Crown – Full Cast Predmntly Base Metal	$276
D2792	Crown – Full Cast Noble Metal	$308
D2794	Crown – Titanium and Titanium Alloys	$328
D2910	Recmnt or Rebnd Inlay/Onlay/Veneer/Partial Covrge	$43
D2915	Recmnt or Rebnd Fabrctd/Prefabrctd Post/Core	$41
D2920	Recmnt or Rebnd Crown	$46
D2930	Prefabrctd Stainless Steel Crown – Prim	$121
D2931	Prefabrctd Stainless Steel Crown – Perm	$109
D2932	Prefabrctd Resin Crown	$128
D2934	Prefabrctd Esthetic Coat Stainless Steel Crown	$133
D2940	Protective Restoration	$45
D2950	Core Buildup Including Any Pins	$139

†This table includes amounts for common covered services. This isn't a complete list. To find out about other covered services, call Member Service at the toll-free phone number shown on your Dental Blue ID card.

(continued)

TABLE OF ALLOWANCE (CONT.)†

Major Restorative Services (cont.)

D2951	Pin Retention – Per Tooth Addn to Restoration	$20
D2952	Post and Core in Addn to Crown Indirectly Fabrctd	$115
D2954	Prefabrctd Post and Core in Addn to Crown	$97
D2990	Resin Infiltration of Incipient Lesions	$38

Endodontic Services

D3230	Pulpal Therapy – Anterior Prim Tooth	$98
D3240	Pulpal Therapy – Posterior Prim Tooth	$110
D3310	Endodontic Therapy – Anterior Tooth	$444
D3320	Endodontic Therapy – Bicuspid Tooth	$528
D3330	Endodontic Therapy – Molar	$650
D3352	Apex/Recalcification – Interim Medctn Rplcmnt	$61
D3353	Apex/Recalcification – Final Visit	$64
D3355	Pulpal Regeneration – Initial Visit	$84
D3356	Pulpal Regeneration – Interim Medctn Rplcmnt	$61
D3357	Pulpal Regeneration – Compltn of Treatment	$64
D3410	Apicoectomy – Anterior	$428
D3421	Apicoectomy – Bicuspid First Root	$388
D3425	Apicoectomy – Molar First Root	$409
D3426	Apicoectomy – Ea Addnl Root	$213

Periodontic Services

D4210	Gingivectomy/Plasty – 4+ Contig Teeth/Quad	$281
D4211	Gingivectomy/Plasty – 1 to 3 Contig Teeth/Quad	$108
D4240	Gingival Flap Procedure – 4+ Contig Teeth/Quad	$425
D4241	Gingival Flap Procedure – 1 to 3 Contig Teeth/Quad	$269
D4260	Osseous Surgery – 4+ Contig Teeth/Quad	$651
D4261	Osseous Surgery – 1 to 3 Contig Teeth/Quad	$503
D4273	Autogns Connctv Tissue Graft Procedure	$524
D4274	Distal or Proximal Wedge Procedure	$258
D4277	Soft Tissue Graft Procedure	$511
D4278	Soft Tissue Graft Procedure – Ea Addtnl Site	$213
D4283	Autogns Connctv Tissue Graft – Ea Addnl Site	$231
D4285	Non-Autogns Connctv Tissue Graft – Ea Addnl Site	$213
D4341	Peridntl Sclng and Root Planng – 4+ Teeth/Quad	$125
D4342	Peridntl Sclng and Root Planng – 1 to 3 Teeth/Quad	$75
D4346	Full Mouth Scaling Gingival Inflammation	$70
D4381	Localized Delivery of Antimicrobial Agents	$45
D4910	Periodontal Maintenance	$63

Removable Prosthodontics

D5110	Complete Denture – Maxillary	$368
D5120	Complete Denture – Mandibular	$368
D5130	Immediate Denture – Maxillary	$376
D5140	Immediate Denture – Mandibular	$376
D5211	Maxillary Partial Denture – Resin Base	$292
D5212	Mandibular Partial Denture – Resin Base	$292
D5213	Maxillary Prtl Dntr – Cst Mtl Frmwrk w/Resin Base	$405
D5214	Mandibular Prtl Dntr – Cst Mtl Frmwrk w/Resin Base	$405

Removable Prosthodontics (cont.)

D5221	Immediate Maxillary Partial Denture – Resin Base	$292
D5222	Immediate Mandibular Partial Denture – Resin Base	$292
D5223	Immediate Maxillary Prtl Dntr – Cst Mtl Frmwrk	$405
D5224	Immediate Mandibular Prtl Dntr – Cst Mtl Frmwrk	$405
D5225	Maxillary Partial Denture – Flexible Base	$373
D5226	Mandibular Partial Denture – Flexible Base	$373
D5282	Removable Unilateral Prtl Dntr – 1 Pc. Cst Mtl	$210
D5283	Removable Unilateral Prtl Dntr – 1 Pc. Cst Mtl, Man	$210
D5284	Removable Unilateral Prtl Dntr – 1 Pc. Flex Base Per Quad	$189
D5286	Removable Unilateral Prtl Dntr – 1 Pc. Resin Base Per Quad	$189
D5520	Replace Missing or Broken Teeth – Complete Denture	$64
D5630	Repair or Replace Broken Retntv Clasp – Per Tooth	$85
D5640	Repair Broken Teeth – Per Tooth	$64
D5650	Add Tooth to Existing Partial Denture	$81
D5660	Add Clasp to Existing Partial Denture – Per Tooth	$92
D5670	Repl All Teeth and Acrylic on Cst Mtl Frmwrk Max	$251
D5671	Repl All Teeth and Acrylic on Cst Mtl Frmwrk Man	$251
D5730	Reline Complete Maxillary Denture – Direct	$128
D5731	Reline Complete Mandibular Denture – Direct	$128
D5740	Reline Maxillary Partial Denture – Direct	$128
D5741	Reline Mandibular Partial Denture – Direct	$128
D5750	Reline Complete Maxillary Denture – Indirect	$180
D5751	Reline Complete Mandibular Denture – Indirect	$180
D5760	Reline Maxillary Partial Denture – Indirect	$160
D5761	Reline Mandibular Partial Denture – Indirect	$160

Fixed Prosthodontics

D6010	Surgical Placement of Implant Body – Endosteal	$617
D6011	Second Stage Implant Surgery	$30
D6013	Surgical Placement of Mini Implant	$283
D6056	Prefabrctd Abutmnt – Includes Placement	$217
D6057	Custom Abutmnt – Includes Placement	$219
D6058	Abutmnt Porcelain/Ceramic Crown	$367
D6059	Abutmnt Porcelain to Mtl Crown – High Noble Mtl	$396
D6060	Abutmnt Porcelain to Mtl Crown – Base Mtl	$324
D6061	Abutmnt Porcelain to Mtl Crown – Noble Mtl	$348
D6062	Abutmnt Cast Mtl Crown – High Noble Mtl	$339
D6063	Abutmnt Cast Mtl Crown – Base Mtl	$310
D6064	Abutmnt Cast Mtl Crown – Noble Mtl	$324
D6065	Implant Porcelain/Ceramic Crown	$361
D6066	Implant Porcelain Fused to High Noble Alloys	$362
D6067	Implant Supported Crown High Noble Alloys	$354
D6082	Implant Supported Crown Porcelain Fused Base Alloys	$332
D6083	Implant Supported Crown Porcelain Fused Noble Alloys	$353
D6084	Implant Supported Crown Porcelain Fused Titanium Alloys	$361
D6086	Implant Supported Crown Base Alloys	$326
D6087	Implant Supported Crown Noble Alloys	$347
D6088	Implant Supported Crown Titanium Alloys	$354
D6092	Recmnt Implant/Abutmnt Supported Crown	$29
D6093	Recmnt Implant/Abutmnt Fixed Partial Denture	$44

† This table includes amounts for common covered services. This isn't a complete list. To find out about other covered services, call Member Service at the toll-free phone number shown on your Dental Blue ID card.

(continued)

TABLE OF ALLOWANCE (CONT.)†

Fixed Prosthodontics (cont.)

D6094	Abutmnt Crown – Titanium Alloys	$335
D6095	Repair Implant Abutmnt by Report	$73
D6097	Abutment Supported Crown Porcelain to Titanium Alloys	$396
D6100	Surgical Removal of Implant Body	$60
D6210	Pontic – Cast High Noble Metal	$341
D6211	Pontic – Cast Predmntly Base Metal	$265
D6212	Pontic – Cast Noble Metal	$281
D6214	Pontic – Titanium and Titanium Alloys	$342
D6240	Pontic – Porcelain to High Noble Metal	$343
D6241	Pontic – Porcelain to Predmntly Base Metal	$301
D6242	Pontic – Porcelain to Noble Metal	$298
D6243	Pontic – Porcelain to Titanium Alloys	$342
D6245	Pontic – Porcelain/Ceramic	$330
D6250	Pontic – Resin with High Noble Metal	$282
D6251	Pontic – Resin with Predmntly Base Metal	$236
D6252	Pontic – Resin with Noble Metal	$248
D6545	Retainer – Cast Metal Resin-Bnded Prosthesis	$128
D6548	Retainer – Porcelain/Ceramic Resin-Bnded Prosthesis	$147
D6600	Retainer Inlay – Porcelain/Ceramic 2 Surfaces	$161
D6601	Retainer Inlay – Porcelain/Ceramic 3+ Surfaces	$230
D6602	Retainer Inlay – Cast High Noble 2 Surfaces	$199
D6603	Retainer Inlay – Cast High Noble 3+ Surfaces	$258
D6608	Retainer Onlay – Porcelain/Ceramic 2 Surfaces	$278
D6609	Retainer Onlay – Porcelain/Ceramic 3+ Surfaces	$291
D6610	Retainer Onlay – Cast High Noble 2 Surfaces	$208
D6611	Retainer Onlay – Cast High Noble 3+ Surfaces	$350
D6612	Retainer Onlay – Cast Predmntly Base Metal 2 Surf	$210
D6613	Retainer Onlay – Cast Predmntly Bse Metal 3+ Srf	$318
D6614	Retainer Onlay – Cast Noble Metal 2 Surfaces	$201

Fixed Prosthodontics (cont.)

D6615	Retainer Onlay – Cast Noble Metal 3+ Surfaces	$328
D6750	Retainer Crown – Porcelain to High Noble Metal	$343
D6751	Retainer Crown – Porcelain to Predmntly Base Metal	$301
D6752	Retainer Crown – Porcelain to Noble Metal	$298
D6753	Retainer Crown – Porcelain to Titanium Alloy	$342
D6780	Retainer Crown – 3/4 Cast High Noble Metal	$323
D6781	Retainer Crown – 3/4 Cast Predmntly Base Metal	$357
D6782	Retainer Crown – 3/4 Cast Noble Metal	$346
D6783	Retainer Crown – 3/4 Porcelain/Ceramic	$346
D6784	Retainer Crown – 3/4 Titanium Alloys	$342
D6790	Retainer Crown – Full Cast High Noble Metal	$339
D6791	Retainer Crown – Full Cast Predmntly Base Metal	$265
D6792	Retainer Crown – Full Cast Noble Metal	$281
D6794	Retainer Crown – Titanium and Titanium Alloys	$342
D6930	Recement Fixed Partial Denture	$59
D6980	Fixed Partial Denture Repair by Report	$108
D6985	Pediatric Partial Denture Fixed	$380

Oral and Maxillofacial Surgery

D7111	Extraction – Coronal Remnants Deciduous Tooth	$40
D7140	Extraction – Erupted Tooth or Exposed Root	$70
D7210	Surgical Removal of Erupted Tooth, Removal of Bone	$130
D7220	Removal Impacted Tooth – Soft Tissue	$167
D7230	Removal Impacted Tooth – Partially Bony	$215
D7240	Removal Impacted Tooth – Completely Bony	$255
D7250	Surgical Removal Residual Tooth Roots	$123
D7471	Removal of Lateral Exostosis	$196
D7472	Removal of Torus Palatinus	$196
D7473	Removal of Torus Mandibularis	$196

† This table includes amounts for common covered services. This isn't a complete list. To find out about other covered services, call Member Service at the toll-free phone number shown on your Dental Blue ID card.

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MASSACHUSETTS

DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

At Blue Cross Blue Shield of Massachusetts, we know 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.

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. 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 doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third 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 we're working to improve health care for all our members.

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
- You remain a member of the plan throughout the benefit period
- You don't exceed the claim payment threshold in the benefit period

If your dental plan's annual maximum benefit amount is:	And if your total claims don't exceed this amount for the benefit period:*	We'll 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 a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.

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MASSACHUSETTS

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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55-1487 (3/24)

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។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. 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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