Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

Preferred Blue® Dental PPO Plan for Idaho School Benefit Trust

Summary of Benefits Cottonwood School District 242 Effective Date September 1, 2018	Preferred Blue® Dental PPO Plan for Idaho School Benefit Trust - Option 1	
Individual/Family Deductible (Deductible applies to In-Network basic, major services, and all Out-of-network services.)	$50/3 Family Maximum	
Individual Benefit Period Maximum	$1,500	
In/Out-of-Network	**In-Network**	**Out-of-Network**.
	By choosing an In-Network provider you pay only cost sharing amounts for allowed charges.	By choosing an Out-of-Network provider you pay your deductible, cost sharing, and are responsible for the difference between what Blue Cross allows and what the Out-of-Network provider charges*
Preventive Services		
Oral Examinations One (1) examination every six (6) months.	You pay nothing of the allowed amount	By choosing an Out-of-Network provider you pay 20% of the allowed amount*
Fluoride One (1) application per benefit period for enrolled eligible dependent children.		
Sealants: Limited to permanent posterior unrestored dentition of eligible dependent children under age sixteen (16) and limited to one (1) time per tooth in any three (3) consecutive benefit periods.		
X-rays, Bitewings Once per benefit period.		
X-rays, Complete Mouth Series or Panoramic x-ray One (1) time in any five (5) consecutive benefit periods.		
Prophylaxis (Cleaning) Once every six (6) months. (Regardless of type)		
Basic Services		
Filings Restorations involving multiple surfaces will be combined and paid according to the number of surfaces treated; same tooth surface restoration is covered once in two (2) benefit periods.	You pay 20% of the allowed amount	By choosing an Out-of-Network provider you pay 30% of the allowed amount*
Extractions		
Root Canal Therapy		
Periodontal Maintenance Once every six (6) months. (Regardless of type)		
Scaling and Root planing Once per quadrant of the mouth every three (3) benefit periods.		
Occlusal Guard One appliance every two (2) benefit periods.		
Osseous Surgery Once per area of the mouth every three (3) years.		
Space Maintainers For enrolled eligible dependent children under age sixteen (16).		
Major Services Preauthorization required on all major services		
Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures Five (5) year replacement.	You pay 50% of the allowed amount	By choosing an Out-of-Network provider you pay 60% of the allowed amount*
Dental Implants Including the implant body, implant abutment and implant crown – benefits may be available up to the Maximum Allowance of a standard complete or partial denture, or bridge. Implant body and abutment-limited to once per tooth per lifetime. Implant crown –five (5) year replacement.		

***By choosing an Out-of-Network provider you pay your cost sharing, deductible, and any difference between what Blue Cross of Idaho allows and what the Out-of-Network provider charges.**

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This information is for comparison purposes only and not a completed description of benefits. All descriptions of coverage are subject to the provisions of the corresponding plan, which contains all the terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the plan issued for a complete description of benefits, exclusions, limitations and conditions of coverage. If there is a difference between this comparison and its corresponding plan, the plan will control. This comparison is subject to annual update and may not reflect the information contained in the corresponding plan.

Exclusions and Limitations

In addition to any other exclusions and limitations of this Plan, the exclusions and limitations listed below apply to this particular section and throughout the entire Plan, unless otherwise specified. No benefits are available under this Plan for the following:

- Procedures that are not included in the Closed List of Dental Covered Services; or that are not Medically Necessary for the care of a Participant's covered dental condition; or that do not have uniform professional endorsement.
- Charges for services that were started prior to the Participant's Effective Date. The following guidelines will be used to determine the date when a service is deemed to have been started:
  - For full dentures or partial dentures: on the date the final impression is taken.
  - For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared.
  - For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex.
  - For periodontal Surgery: on the date the Surgery is actually performed.
  - For all other services: on the date the service is performed.
  - For orthodontic services, if benefits are available under this Plan: on the date any bands or other appliances are first inserted.
- Cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgamor composite fillings).
- Replacement of an existing crown, inlay or onlay that was installed within the preceding five (5) years or replacement of an existing crown, inlay or onlay that can be repaired.
- Appliances, restorations or other services provided or performed solely to change, maintain or restore vertical dimension or occlusion.
- A service for cosmetic purposes, unless necessitated as a result of Accidental Injuries received while the Participant was covered by BCI.
- In excess of the Maximum Allowance.
- A partial or full removable denture for fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding five (5) years.
- Orthodontic services and supplies unless otherwise specifically listed in the Closed List of Dental Covered Services.
- Replacement of lost or stolen appliances.
- Ridge augmentation procedures.
- Any procedure, service or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla or mandible for a prosthetic appliance. Excluded services include, but are not limited to, vestibuloplasty, stomatoplasty and bone grafts (either synthetic or autogenous) to the alveolars, maxilla or mandible.
- Any procedure, service or supply required directly or indirectly to treat a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.
- Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.
- Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable.
- Any service, procedure or supply for which the prognosis for success is not reasonably favorable as determined by BCI.
- Myofunctional therapy and biofeedback procedures.
- For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures.
- Diagnostic casts.
- Occlusal adjustments.
- Not prescribed by or upon the direction of a Provider.
- Investigational in nature;
- Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Participant is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Participant claims such benefits or compensation or recovers losses from a third party.

- Provided or paid for by any federal governmental entity or unit except when payment under this Plan is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefor would vary, or are or would be affected by the existence of coverage under this Plan
- Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.
- Furnished by a Provider who is related to the Participant by blood or marriage and who ordinarily dwells in the Participant's household.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- For personal hygiene, comfort, beautification or convenience items even if prescribed by a Dentist, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs.
- For telephone consultations; for failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Dentist or other Provider.
- For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.
- For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.
- For treatment or other health care of any Participant in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Participant to Covered Services under this Plan, if and to the extent those benefits are payable to or due the Participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's or other similar Plan of insurance, contract or underwriting plan.

  In the event Blue Cross of Idaho for any reason makes payment for or otherwise provides benefits excluded by this provision, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Participant, and the Participant 's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Participant or his or her estate for such services, supplies, drugs or other charges so provided by Blue Cross of Idaho in connection with such Illness, Disease, Accidental Injury or other condition.
- Any services or supplies for which a Participant would have no legal obligation to pay in the absence of coverage under this Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.
- Provided to persons who were enrolled as Eligible Dependents after they cease to qualify as Eligible Dependents due to a change in Eligibility status which occurs during the Plan term.
- Provided outside the United States, which if had been provided in the United States, would not be Covered Services under this Plan.
- Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.
- For acupuncture or hypnosis.
- Repair, removal, cleansing or reinsertion of Implants.
- Precision or semi-precision attachments (including implants placed to support a fixed or removable denture).
- Denture duplication.
- Oral hygiene instruction.
- Treatment of jaw fractures.
- Charges for acid etching.
- Charges for oral cancer screening which are included in a regular oral examination.
- No benefits are available for replacement and/or repair of orthodontic appliances. This includes removable and/or fixed retainers.