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

Preferred Blue® Dental PPO

Summary of Benefits Payette School Dist. 9/1/2014	Preferred Blue® Dental PPO Option 1	
Individual/Family Deductible (Deductible applies to In-Network basic, major services, and all Out-of-network services.)	$50/$150	
Individual Benefit Period Maximum	$1,000	
Dental Maximum Carryover (You may carry over a portion of your unused dental benefits from one year to the next)*	No	
	In-Network	**Out-of-Network**
In/Out-of-Network	By choosing an In-Network provider you pay only coinsurance amounts for allowed charges.	By choosing an Out-of-Network provider you pay your deductible, coinsurance, and are responsible for the difference between what Blue Cross allows and what the Out-of-Network provider charges**
Preventive Services		
Oral Examinations One examination every six months.	You pay nothing	By choosing an Out-of-Network provider you pay 20% of the allowed amount**
Fluoride Limited to one (1) application per benefit period and limited to insured's who are under age twenty-six (26).		
Sealants: Limited to permanent posterior unrestored dentition of Insureds under age sixteen (16). Also 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 time in any five consecutive benefit periods.		
Prophylaxis (Cleaning) Once every six months. (Regardless of type)		
Basic Services		
Fillings 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 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 months. (Regardless of type)		
Scaling and Root planing Once per quadrant of the mouth every three benefit periods.		
Occlusal Guard One appliance every two benefit periods.		
Osseous Surgery Once per area of the mouth every three years.		
Space Maintainers Limited to Insured's who are under age sixteen (16). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.		
Major Services Preauthorization required on all major services		
Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures Five year replacement.	You pay 50% of the allowed amount	By choosing an Out-of-Network provider you pay 60% of the allowed amount**

The Preferred Provider Organization (PPO) dental program offers access to a large network of dental providers who have agreed to offer covered services at or below established maximum allowances, and, by choosing an in-network PPO provider, you maximize your dental benefit dollars.

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***See Group Master Policy for requirements of the Dental Maximum Carryover, if this is a selected benefit.**

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

This summary describes the general features of this program; it is not a contract. All provisions of the Group Master Policy apply to this program.

Exclusions and Limitations

In addition to any other exclusions and limitations of this Policy, the exclusions and limitations listed below apply to this particular section and throughout the entire Policy, unless otherwise specified. No benefits are available under this Policy 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 an Insured's covered dental condition; or that do not have uniform professional endorsement; or that are Investigative in nature.
- Charges for services that were started prior to the Insured's Effective Date. The following guidelines are used to determine the date when a service is deemed to have been started:
  - For full dentures or partial dentures: the date the final impression is taken.
  - For fixed bridges, crowns, inlays or onlays: the date the teeth are first prepared.
  - For root canal therapy: the later of the date the pulp chamber is opened or the date canals are explored to the apex.
  - For periodontal Surgery: the date the Surgery is actually performed.
  - For all other services: the date the service is performed.
  - For orthodontic services, if benefits are available under this Policy: 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 amalgam or 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 Insured was covered by BCI.
- Services or supplies required to correct a Congenital Anomaly or developmental malformation unless the Insured is a dependent child.
- A partial or full removable denture or 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, myofacial 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; biofeedback procedures; athletic mouth guards; precision of semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures; charges for acid etching; or charges for oral cancer screenings which are included in a regular oral examination.
- Diagnostic casts.
- Occlusal adjustments.
- No benefits are available for replacement and/or repair of orthodontic appliances. This includes removable and/or fixed retainers.