Preferred Blue® Dental PPO Plan for Statewide Schools

Summary of Benefits Payette School District 371 : Effective 09/01/2017	Preferred Blue® Dental PPO Plan for Statewide Schools 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	
	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. **Fluoride** One application per benefit period for enrolled eligible dependent children. **Sealants:** Limited to permanent posterior unrestored dentition of eligible dependent children under age 16 and limited to one time per tooth in any three 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)	You pay nothing of the allowed amount	By choosing an Out-of-Network provider you pay 20% of the allowed amount*
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. **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** For enrolled eligible dependent children under age 16.	You pay 20% of the allowed amount	By choosing an Out-of-Network provider you pay 30% of the allowed amount*
Major Services Preauthorization required on all major services		
Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures Five year replacement. **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 year replacement.	You pay 50% of the allowed amount	By choosing an Out-of-Network provider you pay 60% of the allowed amount*

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***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 Plan apply to this program.

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; or that are Investigative in nature.
- Charges for services that were started prior to the Participant'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 Plan: 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 Participant was covered by BCI.
- Services or supplies required to correct a Congenital Anomaly or developmental malformation unless the Participant 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.