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

Preferred Blue® Dental PPO

Benefit Highlight Sheet [Participating School District Name] and [Effective Date:]		
Preferred Blue® Dental PPO Plan for Idaho School Benefit Trust	**In-Network**	**Out-of-Network**.
Individual/Family Deductible (Deductible applies to In-Network basic, major services, and all Out-of-network services. The Family Deductible is satisfied after three (3) Participants of the same family have met their Individual Deductible.)	$25- 3 Family Maximum	
Individual Benefit Period Maximum	$1,250	
Preventive Services	**What you pay**	
Oral Examinations Two (2) per Benefit Period.	0% of the allowed amount	By choosing an Out-of-Network provider 20% of the allowed amount*
Fluoride Limited to two (2) applications per Benefit Period and limited to Participant's who are under age nineteen (19).		
Sealants: Limited to permanent posterior first (1st) and second (2nd) molars unrestored of Participants under age nineteen (19) and limited to one (1) time per tooth in any three (3) years.		
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) Two (2) per Benefit Period. (Regardless of type)		
Basic Services	**What you pay**	
Filings Restorations involving multiple surfaces will be combined and paid according to the number of unique surfaces treated; same tooth surface restoration is covered once in two (2) year period.	20% of the allowed amount	By choosing an Out-of-Network provider 50% of the allowed amount*
Extractions		
Root Canal Therapy		
Periodontal Maintenance Limited to four (4) per Benefit Period. (Regardless of type). Requires prior periodontal treatment.		
Scaling and Root planing Once per area of the mouth every three (3) years.		
Occlusal Guard One (1) appliance every two (2) years.		
Osseous Surgery One (1) per area once every three (3) years.		
Space Maintainers Limited to Participant'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	**What you pay**	
Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures Seven (7) year replacement.	50% of the allowed amount	By choosing an Out-of-Network provider 60% of the allowed amount*
Dental Implants Including the implant body, implant abutment and implant crown. Implant body and abutment-limited to once per tooth per lifetime. Implant crown – seven (7) 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.**

The information in this Highlight Sheet is for informational and comparison purposes only. It is not a complete summary or description of benefits Coverage is subject to the provisions of the corresponding Plan Documents and Summary Plan Description, which contains the detailed terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan Document and Summary Plan Description issued for a more complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference or conflict between this Highlight Sheet and its corresponding Plan Documents and Summary Plan Description, the Plan Documents and Summary Plan Description will control. This Highlight Sheet is subject to annual update.