Blue Cross of Idaho
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Dental Blue Connect Plan for Idaho School Benefit Trust

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Benefit Highlight Sheet Jefferson School District 251 Effective Date September 1, 2020	**Dental Blue Connect Plan 3 for Idaho School Benefit Trust**
	Contracting Providers*
	What You Pay
Individual Deductible	No Deductible
Annual Maximum	No Annual Maximum
General Office Visit	$25 Copayment per visit
Diagnostic and Preventive Services	
Routine and Emergency Exams	No charge after applicable Office Visit Copayment
All X-rays	
Teeth Cleaning	
Fluoride Treatment	
Sealants	
Head and Neck Cancer Screening	
Oral Hygiene Instruction	
Periodontal Charting	
Periodontal Evaluation	
Restorative Dentistry	
Filings	$25 Copayment per visit
Stainless Steel Crown	
Porcelain-Metal Crown	$300 Copayment per visit.
Prosthodontics	
Complete Upper or Lower Denture	$400 Copayment per visit
Bridge (per Tooth)	$300 Copayment per visit
Endodontics and Periodontics	
Root Canal Therapy — Anterior	$125 Copayment per visit
Root Canal Therapy — Bicuspid	$175 Copayment per visit
Root Canal Therapy — Molar	$200 Copayment per visit
Osseous Surgery (per Quadrant)	$250 Copayment per visit
Root Planing (per Quadrant)	$100 Copayment per visit
Oral Surgery	
Routine Extraction (Single Tooth)	$25 Copayment per visit
Surgical Extraction	$150 Copayment per visit
Orthodontic Services	
Pre-Orthodontic Service (Fee credited toward the Comprehensive Orthodontic Service copayment if patient accepts treatment plan)	$150 Copayment per visit
Comprehensive Orthodontic Service	$2,500 Copayment per visit
Miscellaneous	
Local Anesthesia	No charge after applicable Office Visit Copayment
Dental Lab Fees	
Nitrous Oxide	$20 Copayment per visit
Specialty Office Visit	$30 Copayment per visit
Emergency Office Visit	$25 Copayment per visit
Implants	No charge up to $1,500
Out of Area Emergency Care Reimbursement up to $250	

Supported by Willamette Dental Group – 1.855.4DENTAL (1-855-433-6825)

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.