Preferred Blue® Dental PPO

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Benefit Highlight Sheet Jefferson School District 251 Effective Date September 1, 2020		
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.)	$50/3 Family Maximum	
Individual Benefit Period Maximum	$1,250	
Preventive Services	**What you pay**	
Oral Examinations One (1) examination every six (6) months.	No charge of the allowed amount	By choosing an Out-of-Network provider 20% of the allowed amount*
Fluoride Limited to one (1) application per benefit period and limited to Participant's who are under age twenty-six (26).		
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	**What you pay**	
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) year period.	20% of the allowed amount	By choosing an Out-of-Network provider 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 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.		

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Major Services Preauthorization required on all major services	**What you pay**	
Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures Five (5) year replacement.	50% of the allowed amount	By choosing an Out-of-Network provider 50% 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.	50% of the allowed amount	By choosing an Out-of-Network provider 50% of the allowed amount*

***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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