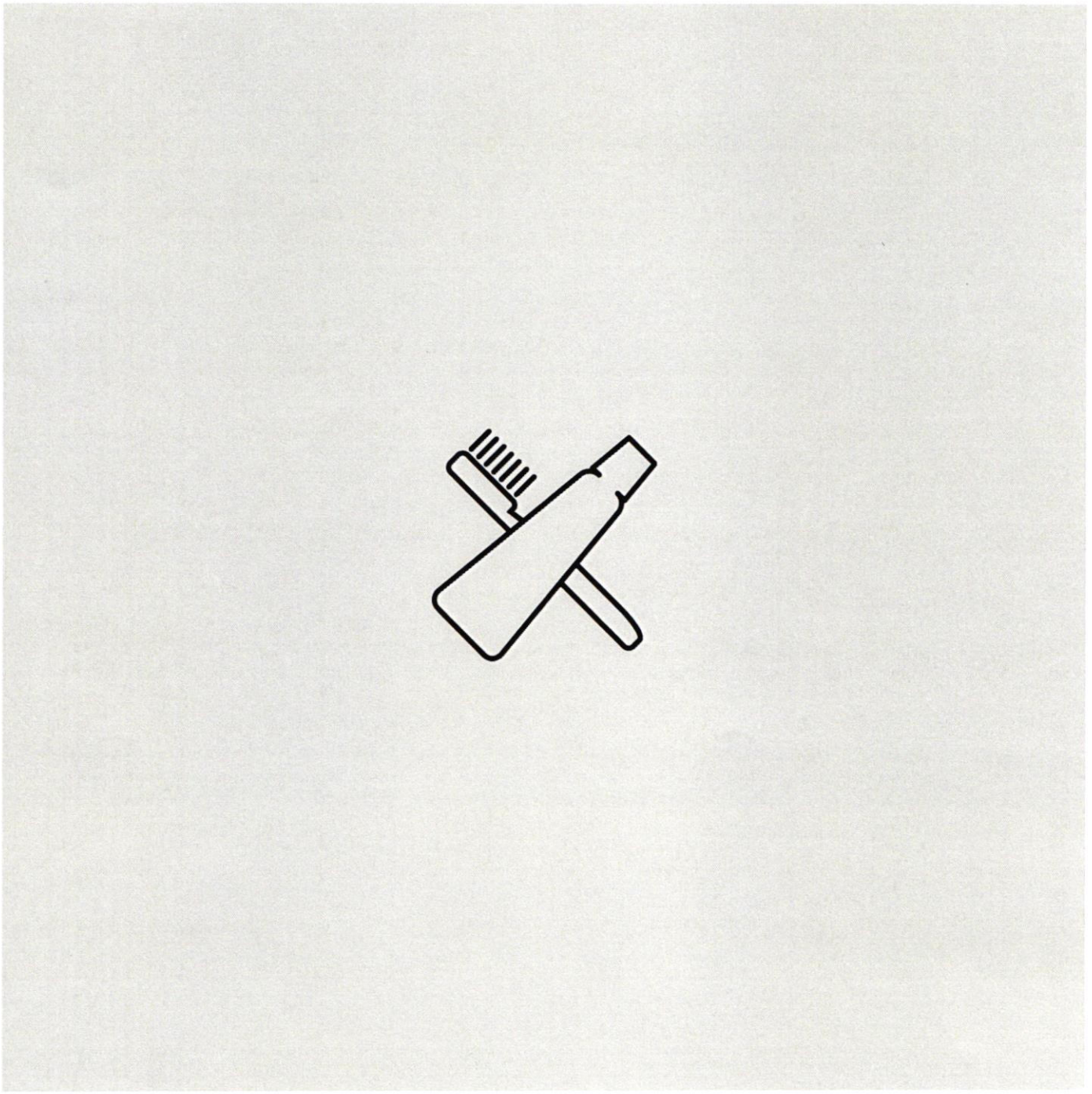

Dental

Blue Cross of Idaho - Willamette

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

Dental Blue Connect Plan for Idaho School Benefit Trust

Benefit Highlight Sheet: Jefferson School District 251 Effective Date: 9/1/2021	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
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	
Fillings	$25 Copayment
Porcelain-Metal Crown	$300 Copayment
Prosthodontics	
Complete Upper or Lower Denture	$400 Copayment
Bridge (per Tooth)	$300 Copayment
Endodontics and Periodontics	
Root Canal Therapy — Anterior	$125 Copayment
Root Canal Therapy — Bicuspid	$175 Copayment
Root Canal Therapy — Molar	$200 Copayment
Osseous Surgery (per Quadrant)	$250 Copayment
Root Planing (per Quadrant)	$100 Copayment
Oral Surgery	
Routine Extraction (Single Tooth)	$25 Copayment
Surgical Extraction	$150 Copayment
Orthodontic Services	
Pre-Orthodontic Service (Fee credited toward the Comprehensive Orthodontic Service copayment if patient accepts treatment plan)	$150 Copayment
Comprehensive Orthodontic Service	$2,500 Copayment
Miscellaneous	
Local Anesthesia	No charge after applicable Office Visit Copayment
Dental Lab Fees	
Nitrous Oxide	$20 Copayment
Specialty Office Visit	$30 Copayment
Emergency Office Visit	$25 Copayment
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.