BlueCross BlueShield Nebraska

An Overview of Your

Dental Benefits

Educators Health Alliance

A Dental Plan Exclusively for

Educators Health Alliance Members

Something to Smile About...

The EHA makes five dental plan options available to school groups. See the Schedule of Benefits Summaries (SOBS) on the following pages for a brief overview of the benefits of each option.

If you enroll in an EHA medical plan, you must also enroll in an EHA dental plan. (Your spouse and children may also enroll in EHA dental coverage if you enroll in an EHA medical and dental plan. An additional cost may apply for the dental plan.)

Important Note about the Two Types of EHA Dental Plans

Options 2, 4 and 5 – benefits are paid at a higher level when in-network dentists are used. For more information, see the SOBS for options 2, 4 and 5 on the following pages.

Options 1 and 3 – benefits are paid at the same level regardless of whether an in-network or out-of-network dentist is used. However, you can save money by using a Blue Cross and Blue Shield of Nebraska in-network dentist. For more information about our network, see page 14.

Options 2, 4 and 5 are governed by a different contract than Options 1 and 3. There are differences in covered services and what services are covered under each category. Covered services are reimbursed based on the allowable charge. Blue Cross and Blue Shield of Nebraska in-network providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the covered person's responsibility. That means that in-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the contracted amount. Out-of-network providers can bill for amounts over the out-of-network allowance.

OPTION 1

Schedule of Benefits Summary

Covered Services are reimbursed based on the Allowable Charge. BlueCross and BlueShield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means that In-Network providers, under the terms of their contract with BlueCross and BlueShield, can't bill for amounts over the Contracted Amount. Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.

Payments for Services	In-Network Provider	Out-of-Network Provider
Deductible (the amount the covered person pays each calendar year for combined covered services before the coinsurance is payable)		
Individual	$25	$25
Family	$50	$50
Calendar year deductible applies to the following coverage benefits	B Services	B Services
Coinsurance Benefits (% covered person pays)		
Coverage A (Preventive and Diagnostic)	0%	0%
Coverage B (Maintenance, Simple Restorative, Oral Surgery)	25%	25%
Coverage C (Complex Restorative, Periodontics and Endodontics)	Not Covered	Not Covered
Coverage D (Orthodontic Dentistry)	Not Covered	Not Covered

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Coverage For Dental Services

Coverage A – Preventive and Diagnostic

- Comprehensive and/or periodic oral exams[1]
- Prophylaxis (cleaning, scaling and polishing)[1]
- Sealants (permanent first or second molar teeth) *(Covered Persons up to age 16) once every four calendar years*
- Pulp vitality tests
- Fluoride varnishes[1]
- Topical fluoride *(Covered Persons up to age 16)*[1]
- Space maintainers, including re-cementation (prematurely lost primary teeth) *(Covered Persons up to age 16)*
- X-rays (bitewing, intraoral, occlusal, periapical, extraoral)
  - supplement bitewings, including vertical bitewings *one set of four every calendar year*
  - intraoral, occlusal, periapical and extraoral
  - panorex or full mouth series *one every three calendar years*

Coverage B – Maintenance, Simple Restorative, Oral Surgery

- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicuspids (orthodontic extractions are not covered)
  - impacted extractions
  - transseptal fiberotomy/supra crestal fiberotomy
  - bone replacement graft
  - appliance removal not by dentist who placed device
  - oroantral fistula closure
  - primary closure of a sinus perforation
  - alveoplasty
  - frenectomy/frenuloplasty
  - removal of torus
  - root removal
  - tooth replantation
  - excision of hyperplastic tissue
- General anesthesia (medically necessary)
- Limited oral evaluation
- Restorations *one per tooth every two calendar years*
- Pin retention
- Palliative treatment
- Dry socket treatment
- Repair and re-cement of dentures, bridges, crowns, inlays/onlays and cast restorations
- Emergency oral examinations
- Consultation with dental consultant (medically necessary)
- Pre-formed crowns[2]
- Temporary crown (within 72 hours of accident)

Coverage C – Complex Restorative Dentistry, Periodontics, Endodontics (NOT COVERED)

- Pontics[2]
- Retainer (cast metal for resin bonded fixed prosthesis) *one every five calendar years*
- Inlays/onlays (used as abutments for fixed bridgework)[2]
- Inlays/onlay restorations[2]
- Sedative filling
- Periodontic services (Non-surgical)
  - periodontic cleanings *four per calendar year*
  - scaling and root planing *four every two calendar years*
  - periodontal evaluations[1]
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement *one every three calendar years*
- Periodontic Services (Surgical)
  - gingivectomy[3]
  - gingival flap procedures[3]
  - osseous surgery, including flap entry and closure[3]
  - osseous graft[3]
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures[3]
  - free soft tissue graft[3]
  - connective tissue graft and double pedicle grafts[3]
  - bone graft[3]
  - biologic materials to aid in soft and osseous tissue regeneration[3]
  - distal or proximal wedge procedures[3]
  - soft tissue allografts[3]
  - crown exposure
  - crown lengthening[4]
- Crowns[2]
- Permanent bridge installation *one every five calendar years*
- Dentures – full and partial *one every five calendar years*
- Denture adjustments *after six months from the date of installation*
- Denture relining *one every three calendar years*
- Post and core
- Core buildup
- Endodontic services (Non-surgical)
  - pulp cap
  - vital pulpotomy[4]
  - pulpal therapy[4]
  - pulpal debridement[4]
  - root canal therapy (treatment plan, diagnostic x-rays, clinical procedures and follow up care)
  - retreatment of previous root canal therapy covered *after six months when performed by a different provider*
  - apexification
- Endodontic Services (Surgical)
  - apicoectomy[4]
  - retrograde filling[4]
  - bone graft[4]
  - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery[4]
  - guided tissue regeneration[4]
  - periradicular surgery[4]
  - root amputation[4]
  - hemisection[4]

Coverage D – Orthodontic Dentistry (NOT COVERED)

- Surgical access, exposure or immobilization (unerupted teeth)
- Placement of device to facilitate eruption (impacted teeth)
- Diagnostic casts *one every two calendar years*
- Orthodontic appliances (initial and subsequent installations)
- Cephalometric x-rays
- Extractions
- Casts and models

1 two every calendar year 2 one per tooth every five calendar years 3 four every five calendar years 4 once per tooth while covered under the Plan

OPTION 2

Schedule of Benefits Summary

Covered Services are reimbursed based on the Allowable Charge. BlueCross and BlueShield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means that In-Network providers, under the terms of their contract with BlueCross and BlueShield, can't bill for amounts over the Contracted Amount. Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.

Payments for Services	In-Network Provider	Out-of-Network Provider
Deductible (the amount the covered person pays each calendar year for combined covered services before the coinsurance is payable)		
Individual	$25	$50
Family	$50	$100
Calendar year deductible applies to the following coverage benefits	B & C Services	B & C Services
Coinsurance Benefits (% covered person pays)		
Coverage A (Preventive and Diagnostic)	0%	50%
Coverage B (Maintenance, Simple Restorative, Oral Surgery, Periodontics and Endodontics)	25%	50%
Coverage C (Complex Restorative)	50%	50%
Coverage D (Orthodontic Dentistry)	Not Covered	Not Covered

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Coverage For Dental Services

Coverage A – Preventive and Diagnostic

- Comprehensive and/or periodic oral exams[1]
- Prophylaxis (cleaning, scaling and polishing)[1]
- Sealants (permanent first or second molar teeth) *(Covered Persons up to age 16) once every four calendar years*
- Pulp vitality tests
- Fluoride varnishes[1]
- Topical fluoride *(Covered Persons up to age 16)*[1]
- Space maintainers, including re-cementation (prematurely lost primary teeth) *(Covered Persons up to age 16)*
- X-rays (bitewing, intraoral, occlusal, periapical, extraoral)
  - supplement bitewings, including vertical bitewings *one set of four every calendar year*
  - intraoral, occlusal, periapical and extraoral
  - panorex or full mouth series *one every three calendar years*

Coverage B – Maintenance, Simple Restorative, Oral Surgery, Periodontic, Endodontics

- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicuspids (orthodontic extractions are not covered)
  - impacted extractions
  - transseptal fiberotomy/supra crestal fiberotomy
  - bone replacement graft
  - appliance removal not by dentist who placed device
  - oroantral fistula closure
  - primary closure of a sinus perforation
  - alveoplasty
  - frenectomy/frenuloplasty
  - removal of torus
  - root removal
  - tooth replantation
  - excision of hyperplastic tissue
- Periodontic services (Non-surgical)
  - periodontic cleanings *four per calendar year*
  - scaling and root planing *four every two calendar years*
  - periodontal evaluations[1]
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement *one every three calendar years*
- Periodontic Services (Surgical)
  - gingivectomy[3]
  - gingival flap procedures[3]
  - osseous surgery, including flap entry and closure[3]
  - osseous graft[3]
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures[3]
  - free soft tissue grafts[3]
  - connective tissue graft and double pedicle graft[3]
  - bone graft[3]
  - biologic materials to aid in soft and osseous tissue regeneration[3]
  - distal or proximal wedge procedures[3]
- Periodontic Services (Surgical) *continued*
  - soft tissue allografts[3]
  - crown exposure
  - crown lengthening[4]
- General anesthesia (medically necessary)
- Limited oral evaluation
- Restorations *one per tooth every two calendar years*
- Pin retention
- Palliative treatment
- Dry socket treatment
- Repair and re-cement of dentures, bridges, crowns, inlays/onlays and cast restorations
- Emergency oral examinations
- Consultation with dental consultant (medically necessary) Pre-formed crowns[2]
- Temporary crown (within 72 hours of accident)
- Endodontic services (Non-surgical)
  - pulp cap
  - vital pulpotomy[4]
  - pulpal therapy[4]
  - pulpal debridement[4]
  - root canal therapy (treatment plan, x-rays, clinical procedures and follow up care)
  - retreatment of previous root canal therapy covered *after six months when performed by a different provider*
  - apexification
- Endodontic Services (Surgical)
  - apiocoetomy[4]
  - retrograde filling[4]
  - bone graft[4]
  - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery[4]
  - guided tissue regeneration[4]
  - periradicular surgery[4]
  - root amputation[4]
  - hemisection[4]

Coverage C – Complex Restorative Dentistry

- Pontics[2]
- Retainer (cast metal for resin bonded fixed prosthesis) *one every five calendar years*
- Inlays/onlays (used as abutments for fixed bridgework)[2]
- Inlays/onlay restorations[2]
- Sedative filling
- Crowns[2]
- Permanent bridge installation *one every five calendar years*
- Dentures – full and partial *one every five calendar years*
- Denture adjustments *after six months from the date of installation*
- Denture relining *one every three calendar years*
- Post and core
- Core buildup

Coverage D – Orthodontic Dentistry (NOT COVERED)

- Surgical access, exposure or immobilization (unerupted teeth)
- Placement of device to facilitate eruption (impacted teeth)
- Diagnostic casts *one every two calendar years*
- Orthodontic appliances (initial and subsequent installations)
- Cephalometric x-rays
- Extractions
- Casts and models

1 two every calendar year 2 one per tooth every five calendar years 3 four every five calendar years 4 once per tooth while covered under the Plan

OPTION 3

Schedule of Benefits Summary

Covered Services are reimbursed based on the Allowable Charge. BlueCross and BlueShield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means that In-Network providers, under the terms of their contract with BlueCross and BlueShield, can't bill for amounts over the Contracted Amount. Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.

Payments for Services	In-Network Provider	Out-of-Network Provider
Deductible (the amount the covered person pays each calendar year for combined covered services before the coinsurance is payable)		
Individual	$25	$25
Family	$50	$50
Calendar year deductible applies to the following coverage benefits	B & C Services	B & C Services
Coinsurance Benefits (% covered person pays)		
Coverage A (Preventive and Diagnostic)	0%	0%
Coverage B (Maintenance, Simple Restorative, Oral Surgery, Periodontics and Endodontics)	20%	20%
Coverage C (Complex Restorative)	30%	30%
Coverage D (Orthodontic Dentistry)	Not Covered	Not Covered

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Coverage For Dental Services

Coverage A – Preventive and Diagnostic

- Comprehensive and/or periodic oral exams[1]
- Prophylaxis (cleaning, scaling and polishing)[1]
- Sealants (permanent first or second molar teeth) *(Covered Persons up to age 16) once every four calendar years*
- Pulp vitality tests
- Fluoride varnishes[1]
- Topical fluoride *(Covered Persons up to age 16)*[1]
- Space maintainers, including re-cementation (prematurely lost primary teeth) *(Covered Persons up to age 16)*
- X-rays (bitewing, intraoral, occlusal, periapical, extraoral)
  - supplement bitewings, including vertical bitewings *one set of four every calendar year*
  - intraoral, occlusal, periapical and extraoral
  - panorex or full mouth series *one every three calendar years*

Coverage B – Maintenance, Simple Restorative, Oral Surgery, Periodontic, Endodontics

- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicuspids (orthodontic extractions are not covered)
  - impacted extractions
  - transseptal fiberotomy/supra crestal fiberotomy
  - bone replacement graft
  - appliance removal not by dentist who placed device
  - oroantral fistula closure
  - primary closure of a sinus perforation
  - alveoplasty
  - frenectomy/frenuloplasty
  - removal of torus
  - root removal
  - tooth replantation
  - excision of hyperplastic tissue
- Periodontic services (Non-surgical)
  - periodontic cleanings *four per calendar year*
  - scaling and root planing *four every two calendar years*
  - periodontal evaluations[1]
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement *one every three calendar years*
- Periodontic Services (Surgical)
  - gingivectomy[3]
  - gingival flap procedures[3]
  - osseous surgery, including flap entry and closure[3]
  - osseous graft[3]
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures[3]
  - free soft tissue grafts[3]
  - connective tissue graft and double pedicle graft[3]
  - bone graft[3]
  - biologic materials to aid in soft and osseous tissue regeneration[3]
  - distal or proximal wedge procedures[3]
- Periodontic Services (Surgical) *continued*
  - soft tissue allografts[3]
  - crown exposure
  - crown lengthening[4]
- General anesthesia (medically necessary)
- Limited oral evaluation
- Restorations *one per tooth every two calendar years*
- Pin retention
- Palliative treatment
- Dry socket treatment
- Repair and re-cement of dentures, bridges, crowns, inlays/onlays and cast restorations
- Emergency oral examinations
- Consultation with dental consultant (medically necessary) Pre-formed crowns[2]
- Temporary crown (within 72 hours of accident)
- Endodontic services (Non-surgical)
  - pulp cap
  - vital pulpotomy[4]
  - pulpal therapy[4]
  - pulpal debridement[4]
  - root canal therapy (treatment plan, x-rays, clinical procedures and follow up care)
  - retreatment of previous root canal therapy covered *after six months when performed by a different provider*
  - apexification
- Endodontic Services (Surgical)
  - apiocoetomy[4]
  - retrograde filling[4]
  - bone graft[4]
  - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery[4]
  - guided tissue regeneration[4]
  - periradicular surgery[4]
  - root amputation[4]
  - hemisection[4]

Coverage C – Complex Restorative Dentistry

- Pontics[2]
- Retainer (cast metal for resin bonded fixed prosthesis) *one every five calendar years*
- Inlays/onlays (used as abutments for fixed bridgework)[2]
- Inlays/onlay restorations[2]
- Sedative filling
- Crowns[2]
- Permanent bridge installation *one every five calendar years*
- Dentures – full and partial *one every five calendar years*
- Denture adjustments *after six months from the date of installation*
- Denture relining *one every three calendar years*
- Post and core
- Core buildup

Coverage D – Orthodontic Dentistry (NOT COVERED)

- Surgical access, exposure or immobilization (unerupted teeth)
- Placement of device to facilitate eruption (impacted teeth)
- Diagnostic casts *one every two calendar years*
- Orthodontic appliances (initial and subsequent installations)
- Cephalometric x-rays
- Extractions
- Casts and models

1 two every calendar year 2 one per tooth every five calendar years 3 four every five calendar years 4 once per tooth while covered under the Plan

OPTION 4

Schedule of Benefits Summary

Covered Services are reimbursed based on the Allowable Charge. BlueCross and BlueShield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means that In-Network providers, under the terms of their contract with BlueCross and BlueShield, can't bill for amounts over the Contracted Amount. Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.

Payments for Services	In-Network Provider	Out-of-Network Provider
Deductible (the amount the covered person pays each calendar year for combined covered services before the coinsurance is payable)		
Individual	$25	$50
Family	$50	$100
Calendar year deductible applies to the following coverage benefits	B & C Services	B & C Services
Total Maximum Benefit		
Total amount payable for covered services for each eligible dependent while covered under this plan	$2,000	$2,000
Total maximum benefit applies to the following coverage benefits	D Services	D Services
Coinsurance Benefits (% covered person pays)		
Coverage A (Preventive and Diagnostic)	0%	30%
Coverage B (Maintenance, Simple Restorative, Oral Surgery, Periodontics and Endodontics)	20%	40%
Coverage C (Complex Restorative)	20%	40%
Coverage D (Orthodontic Dentistry)	50%	50%

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Coverage For Dental Services

Coverage A – Preventive and Diagnostic

- Comprehensive and/or periodic oral exams[1]
- Prophylaxis (cleaning, scaling and polishing)[1]
- Sealants (permanent first or second molar teeth) *(Covered Persons up to age 16) once every four calendar years*
- Pulp vitality tests
- Fluoride varnishes[1]
- Topical fluoride *(Covered Persons up to age 16)*[1]
- Space maintainers, including re-cementation (prematurely lost primary teeth) *(Covered Persons up to age 16)*
- X-rays (bitewing, intraoral, occlusal, periapical, extraoral)
  - supplement bitewings, including vertical bitewings *one set of four every calendar year*
  - intraoral, occlusal, periapical and extraoral
  - panorex or full mouth series *one every three calendar years*

Coverage B – Maintenance, Simple Restorative, Oral Surgery, Periodontic, Endodontics

- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicuspids (orthodontic extractions are not covered)
  - impacted extractions
  - transseptal fiberotomy/supra crestal fiberotomy
  - bone replacement graft
  - appliance removal not by dentist who placed device
  - oroantral fistula closure
  - primary closure of a sinus perforation
  - alveoplasty
  - frenectomy/frenuloplasty
  - removal of torus
  - root removal
  - tooth replantation
  - excision of hyperplastic tissue
- Periodontic services (Non-surgical)
  - periodontic cleanings *four per calendar year*
  - scaling and root planing *four every two calendar years*
  - periodontal evaluations[1]
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement *one every three calendar years*
- Periodontic Services (Surgical)
  - gingivectomy[3]
  - gingival flap procedures[3]
  - osseous surgery, including flap entry and closure[3]
  - osseous graft[3]
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures[3]
  - free soft tissue grafts[3]
  - connective tissue graft and double pedicle graft[3]
  - bone graft[3]
  - biologic materials to aid in soft and osseous tissue regeneration[3]
  - distal or proximal wedge procedures[3]
- Periodontic Services (Surgical) *continued*
  - soft tissue allografts[3]
  - crown exposure
  - crown lengthening[4]
- General anesthesia (medically necessary)
- Limited oral evaluation
- Restorations *one per tooth every two calendar years*
- Pin retention
- Palliative treatment
- Dry socket treatment
- Repair and re-cement of dentures, bridges, crowns, inlays/onlays and cast restorations
- Emergency oral examinations
- Consultation with dental consultant (medically necessary) Pre-formed crowns[2]
- Temporary crown (within 72 hours of accident)
- Endodontic services (Non-surgical)
  - pulp cap
  - vital pulpotomy[4]
  - pulpal therapy[4]
  - pulpal debridement[4]
  - root canal therapy (treatment plan, x-rays, clinical procedures and follow up care)
  - retreatment of previous root canal therapy covered *after six months when performed by a different provider*
  - apexification
- Endodontic Services (Surgical)
  - apiocoetomy[4]
  - retrograde filling[4]
  - bone graft[4]
  - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery[4]
  - guided tissue regeneration[4]
  - periradicular surgery[4]
  - root amputation[4]
  - hemisection[4]

Coverage C – Complex Restorative Dentistry

- Pontics[2]
- Retainer (cast metal for resin bonded fixed prosthesis) *one every five calendar years*
- Inlays/onlays (used as abutments for fixed bridgework)[2]
- Inlays/onlay restorations[2]
- Sedative filling
- Crowns[2]
- Permanent bridge installation *one every five calendar years*
- Dentures – full and partial *one every five calendar years*
- Denture adjustments *after six months from the date of installation*
- Denture relining *one every three calendar years*
- Post and core
- Core buildup

Coverage D – Orthodontic Dentistry

- Surgical access, exposure or immobilization (unerupted teeth)
- Placement of device to facilitate eruption (impacted teeth)
- Diagnostic casts *one every two calendar years*
- Orthodontic appliances (initial and subsequent installations)
- Cephalometric x-rays
- Extractions
- Casts and models

1 two every calendar year 2 one per tooth every five calendar years 3 four every five calendar years 4 once per tooth while covered under the Plan

OPTION 5

Schedule of Benefits Summary

Covered Services are reimbursed based on the Allowable Charge. BlueCross and BlueShield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means that In-Network providers, under the terms of their contract with BlueCross and BlueShield, can't bill for amounts over the Contracted Amount. Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.

Payments for Services	In-Network Provider	Out-of-Network Provider
Deductible (the amount the covered person pays each calendar year for combined covered services before the coinsurance is payable)		
Individual	$25	$50
Family	$50	$100
Calendar year deductible applies to the following coverage benefits	B & C Services	B & C Services
Coinsurance Benefits (% covered person pays)		
Coverage A (Preventive and Diagnostic)	0%	20%
Coverage B (Maintenance, Simple Restorative, Oral Surgery, Periodontics and Endodontics)	0%	20%
Coverage C (Complex Restorative)	0%	20%
Coverage D (Orthodontic Dentistry)	Not Covered	Not Covered

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Coverage For Dental Services

Coverage A – Preventive and Diagnostic

- Comprehensive and/or periodic oral exams[1]
- Prophylaxis (cleaning, scaling and polishing)[1]
- Sealants (permanent first or second molar teeth) *(Covered Persons up to age 16) once every four calendar years*
- Pulp vitality tests
- Fluoride varnishes[1]
- Topical fluoride *(Covered Persons up to age 16)*[1]
- Space maintainers, including re-cementation (prematurely lost primary teeth) *(Covered Persons up to age 16)*
- X-rays (bitewing, intraoral, occlusal, periapical, extraoral)
  - supplement bitewings, including vertical bitewings *one set of four every calendar year*
  - intraoral, occlusal, periapical and extraoral
  - panorex or full mouth series *one every three calendar years*

Coverage B – Maintenance, Simple Restorative, Oral Surgery, Periodontic, Endodontics

- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicuspids (orthodontic extractions are not covered)
  - impacted extractions
  - transseptal fiberotomy/supra crestal fiberotomy
  - bone replacement graft
  - appliance removal not by dentist who placed device
  - oroantral fistula closure
  - primary closure of a sinus perforation
  - alveoplasty
  - frenectomy/frenuloplasty
  - removal of torus
  - root removal
  - tooth replantation
  - excision of hyperplastic tissue
- Periodontic services (Non-surgical)
  - periodontic cleanings *four per calendar year*
  - scaling and root planing *four every two calendar years*
  - periodontal evaluations[1]
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement *one every three calendar years*
- Periodontic Services (Surgical)
  - gingivectomy[3]
  - gingival flap procedures[3]
  - osseous surgery, including flap entry and closure[3]
  - osseous graft[3]
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures[3]
  - free soft tissue grafts[3]
  - connective tissue graft and double pedicle graft[3]
  - bone graft[3]
  - biologic materials to aid in soft and osseous tissue regeneration[3]
  - distal or proximal wedge procedures[3]
- Periodontic Services (Surgical) *continued*
  - soft tissue allografts[3]
  - crown exposure
  - crown lengthening[4]
- General anesthesia (medically necessary)
- Limited oral evaluation
- Restorations *one per tooth every two calendar years*
- Pin retention
- Palliative treatment
- Dry socket treatment
- Repair and re-cement of dentures, bridges, crowns, inlays/onlays and cast restorations
- Emergency oral examinations
- Consultation with dental consultant (medically necessary) Pre-formed crowns[2]
- Temporary crown (within 72 hours of accident)
- Endodontic services (Non-surgical)
  - pulp cap
  - vital pulpotomy[4]
  - pulpal therapy[4]
  - pulpal debridement[4]
  - root canal therapy (treatment plan, x-rays, clinical procedures and follow up care)
  - retreatment of previous root canal therapy covered *after six months when performed by a different provider*
  - apexification
- Endodontic Services (Surgical)
  - apiocoetomy[4]
  - retrograde filling[4]
  - bone graft[4]
  - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery[4]
  - guided tissue regeneration[4]
  - periradicular surgery[4]
  - root amputation[4]
  - hemisection[4]

Coverage C – Complex Restorative Dentistry

- Pontics[2]
- Retainer (cast metal for resin bonded fixed prosthesis) *one every five calendar years*
- Inlays/onlays (used as abutments for fixed bridgework)[2]
- Inlays/onlay restorations[2]
- Sedative filling
- Crowns[2]
- Permanent bridge installation *one every five calendar years*
- Dentures – full and partial *one every five calendar years*
- Denture adjustments *after six months from the date of installation*
- Denture relining *one every three calendar years*
- Post and core
- Core buildup

Coverage D – Orthodontic Dentistry (NOT COVERED)

- Surgical access, exposure or immobilization (unerupted teeth)
- Placement of device to facilitate eruption (impacted teeth)
- Diagnostic casts *one every two calendar years*
- Orthodontic appliances (initial and subsequent installations)
- Cephalometric x-rays
- Extractions
- Casts and models

1 two every calendar year 2 one per tooth every five calendar years 3 four every five calendar years 4 once per tooth while covered under the Plan

How Using In-network Dentists

BENEFITS YOU

Our dental network in Nebraska is part of a larger provider network of multiple Blue Cross and Blue Shield Plans that, when combined, offers one of the largest national PPO dental networks and provides you and your covered family members with lower out-of-pocket costs and broad access to participating dentists.

If you or your covered family members live or travel outside of Nebraska, you will be able to obtain covered services at the in-network level of benefits through our dental network.

Noncovered Dental Services

The following is only a partial listing of the exclusions and limitations that apply to EHA dental coverage. A complete list is in the master contract.

- Services not identified as covered under Coverages A, B and C in the contract.
- Dental services related to congenital malformations or primarily for cosmetic purposes.
- Services for orthodontic dentistry (unless covered under Option 4) and treatment of the temporo-mandibular jaw joint.
- Supplies, education or training for dietary or nutrition counseling, personal oral hygiene or dental plaque control.
- Services received before the effective date of coverage or after termination of coverage.
- Services determined to be not medically necessary, investigative, or obsolete.
- Charges in excess of our contracted amount.
- Services covered under Workers' Compensation or Employers' Liability Law.
- Services provided by a person who is not a dentist, or by a dental hygienist not under the dentist's direct supervision.
- Charges made separately for services, supplies and materials considered to be included within the total charge payable.

Membership Changes

If you wish to change your membership category for dental coverage from employee-spouse, employee-child(ren) or family to single, you may do so at any time during the year. You may also change from single to employee-spouse, employee-child(ren) or family dental coverage if you experience a HIPAA qualifying event (birth, death, divorce, marriage, adoption or placement for adoption, or loss in creditable coverage). HIPAA stands for Health Insurance Portability and Accountability Act.

Membership Categories

Single Membership: Covers the employee only.

Employee and Spouse: Covers the employee and his or her spouse.

Employee and Child(ren): Covers the employee and his or her eligible dependent children, but does not provide coverage to a spouse.

Family Membership: Covers the employee, spouse, and eligible dependent children.

The employee's dependent children (excluding foster children) are covered to age 26. Reaching age 26 will not end the covered child's coverage as long as the child is and remains both incapable of self-sustaining employment by reason of mental or physical handicap and is dependent upon the subscriber for support and maintenance.

Blue Cross and Blue Shield of Nebraska
Member Services Department

1-877-721-2583

nebraskablue.com/contact

To locate in-network dentists in Nebraska

1-877-721-2583

nebraskablue.com/find-a-doctor

This brochure contains only a partial description of the benefits, limitations, exclusions and other provisions of Educators Health Alliance dental coverage. It describes the more important parts of the master group contract in a general way, and should not be considered to be all or part of the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

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