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.

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

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### Coverage For Dental Services

#### Coverage A – Preventive and Diagnostic

- Comprehensive and/or periodic oral exams<sup>5</sup>
- Prophylaxis (cleaning, scaling and polishing)<sup>1</sup>
- Sealants (permanent first or second molar teeth) (Covered Persons up to age 18) *once every four calendar years*
- Pulp vitality tests
- Fluoride varnishes<sup>3</sup>
- Topical fluoride (Covered Persons up to age 18)<sup>5</sup>

#### Coverage B – Maintenance, Simple Restorative, Oral Surgery

- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicusps (orthodontic extractions are not covered)
  - impacted extractions
  - transseptal fiberopty/supra crestal fiberoity
  - 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

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

- Pontics<sup>4</sup>
- Retainers (cast metal for resin bonded fixed prosthesis) *one every five calendar years*
- Inlays/onlays (used as abutments for fixed bridgework)<sup>2</sup>
- Inlays/onlay restorations<sup>2</sup>
- Sedative filling
- Periodontic services (Non-surgical)
  - periodontic cleanings *four per calendar year*
  - scaling and root planing *four every two calendar years*
  - periodontal evaluations<sup>1</sup>
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement *one every three calendar years*
- Periodontic Services (Surgical)
  - gingivectomy<sup>3</sup>
  - gingival flap procedures<sup>3</sup>
  - osseous surgery, including flap entry and closure<sup>3</sup>
  - osseous graft<sup>3</sup>
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures<sup>3</sup>
  - free soft tissue graft<sup>2</sup>
  - connective tissue graft and double pedicle grafts<sup>3</sup>
  - bone graft<sup>3</sup>
  - biologic materials to aid in soft and osseous tissue regeneration<sup>3</sup>
  - distal or proximal wedge procedures<sup>3</sup>
  - soft tissue allografts<sup>3</sup>
  - crown exposure
  - crown lengthening<sup>4</sup>
- Endodontic Services (Surgical)
  - apicoectomy<sup>4</sup>
  - retrograde filling<sup>4</sup>
  - bone graft<sup>4</sup>
  - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery<sup>4</sup>
  - guided tissue regeneration<sup>4</sup>
  - periradicular surgery<sup>4</sup>
  - root amputation<sup>4</sup>
  - hemisection<sup>4</sup>

#### 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)

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<sup>1</sup> two every calendar year  
<sup>2</sup> one per tooth every five calendar years  
<sup>3</sup> four every five calendar years  
<sup>4</sup> 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.

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<td>B &amp; C Services</td>
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<tr>
<td>Coinsurance Benefits (% covered person pays)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage A (Preventive and Diagnostic)</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>Coverage B (Maintenance, Simple Restorative, Oral Surgery, Periodontics and Endodontics)</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Coverage C (Complex Restorative)</td>
<td>50%</td>
<td>50%</td>
</tr>
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<td>Coverage D (Orthodontic Dentistry)</td>
<td>Not Covered</td>
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### Coverage For Dental Services

#### Coverage A – Preventive and Diagnostic
- Comprehensive and/or periodic oral exams
- Prophylaxis (cleaning, scaling and polishing)
- Sealants (permanent first or second molar teeth) (Covered Persons up to age 18) once every four calendar years
- Pulp vitality tests
- Fluoride varnishes
- Topical fluoride (Covered Persons up to age 18)
- X-rays (bitewing, intraoral, occlusal, periapical, extraoral) one set of four every calendar year
- intraoral, occlusal, periapical and extraoral
- panoram 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 fibreotomy/supra crestal fibroremy
  - 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
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement one every three calendar years
- Periodontic Services (Surgical)
  - gingivectomy
  - gingival flap procedures
  - osseous surgery, including flap entry and closure
  - osseous grafts
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures
  - free soft tissue grafts
  - connective tissue graft and double pedicle graft
  - bone graft
  - biologic materials to aid in soft and osseous tissue regeneration
  - distal or proximal wedge procedures
- Periodontic Services (Surgical) continued
  - soft tissue allografts
  - crown exposure
  - crown lengthening
  - 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 crowns²
  - Temporary crown (within 72 hours of accident)
  - Endodontic Services (Non-surgical)
    - pulp cap
    - vital pulpotomy
    - pulpal therapy
    - pulpal debridement
    - 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)
    - apicoectomy
    - retrograde filling
    - bone graft
    - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery
    - guided tissue regeneration
    - periradicular surgery
    - root amputation
    - hemisection

#### Coverage C – Complex Restorative Dentistry
- Pontics
- Retainer (cast metal for resin bonded fixed prosthesis) one every five calendar years
- Inlays/onlays (used as abutments for fixed bridgework)²
- Inlays/onlay restorations²
- Sedative filling
- Crowns²
- 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

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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

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OVERVIEW \ 7
## 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.

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</tr>
<tr>
<td>Family</td>
<td>$50</td>
<td>$50</td>
</tr>
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<td>Calendar year deductible applies to the following coverage benefits</td>
<td>B &amp; C Services</td>
<td>B &amp; C Services</td>
</tr>
<tr>
<td><strong>Coinsurance Benefits</strong> (% covered person pays)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage A (Preventive and Diagnostic)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Coverage B (Maintenance, Simple Restorative, Oral Surgery, Periodontics and Endodontics)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Coverage C (Complex Restorative)</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Coverage D (Orthodontic Dentistry)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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### Coverage A – Preventive and Diagnostic
- Comprehensive and/or periodic oral exams
- Prophylaxis (cleaning, scaling and polishing)
- Sealants (permanent first or second molar teeth) (Covered Persons up to age 18) once every four calendar years
- Pulp vitality tests
- Fluoride varnishes
- Topical fluoride (Covered Persons up to age 18)
- Fluoride varnishes

### Coverage B – Maintenance, Simple Restorative, Oral Surgery, Periodontic, Endodontics
- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicusps
  - impacted extractions
  - transseptal fibromy/first supra crestal fibromy
  - 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 reimplantation
  - excision of hyperplastic tissue
- Periodontic services (Non-surgical)
  - periodontic cleanings four per calendar year
  - scaling and root planing four per every two calendar years
  - periodontal evaluations
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement one every three calendar years
- Periodontic Services (Surgical)
  - gingivectomy
  - gingival flap procedures
  - osseous surgery, including flap entry and closure
  - osseous grafts
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures
  - free soft tissue grafts
  - connective tissue graft and double pedicle graft
  - bone graft
  - biologic materials to aid in soft and osseous tissue regeneration
  - distal or proximal wedge procedures

### Coverage C – Complex Restorative Dentistry
- Pontics
- Retainer (cast metal for resin bonded fixed prosthesis) one every five calendar years
- Inlays/onlays (used as abutments for fixed bridgework)
- Inlays/onlay restorations
- Sodative filling
- Crowns

### 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)

---

1 one every calendar year
2 one per tooth every five calendar years
3 four every five calendar years
4 one 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.

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

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<table>
<thead>
<tr>
<th>Coverage A – Preventive and Diagnostic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Comprehensive and/or periodic oral exams³</td>
</tr>
<tr>
<td>• Prophylaxis (cleaning, scaling, and polishing)¹</td>
</tr>
<tr>
<td>• Sealants (permanent first or second molar teeth) (Covered Persons up to age 18) continued every four calendar years</td>
</tr>
<tr>
<td>• Pulp vitality tests</td>
</tr>
<tr>
<td>• Fluoride varnishes³</td>
</tr>
<tr>
<td>• Topical fluoride (Covered Persons up to age 18)</td>
</tr>
<tr>
<td>• Space maintainers, including re-cementation (prematurely lost primary teeth) (Covered Persons up to age 18)</td>
</tr>
<tr>
<td>• 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</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage B – Maintenance, Simple Restorative, Oral Surgery, Periodontic, Endodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Oral surgery consisting of: - simple extractions, including root removal 1st and 2nd bicuspid (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</td>
</tr>
<tr>
<td>• Periodontic Services (Non-surgical) - periodontic cleanings four per calendar year - scaling and root planing four every two calendar years - periodontal evaluations¹ - provisional or permanent periodontal splinting - treatment of acute infection and oral lesions - full mouth debridement one every three calendar years</td>
</tr>
<tr>
<td>• Periodontic Services (Surgical) - gingivectomy³ - gingival flap procedures³ - osseous surgery, including flap entry and closure² - osseous graft³ - guided tissue regeneration including biologic materials - pedicle tissue graft procedures³ - free soft tissue grafts³ - connective tissue graft and double pedicle graft³ - bone graft³ - biologic materials to aid in soft and osseous tissue regeneration³ - distal or proximal wedge procedures³</td>
</tr>
<tr>
<td>• Periodontic Services [Surgical] continued - soft tissue allografts³ - crown exposure - crown lengthening³ - 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 crowns² - Temporary crown (within 72 hours of accident)</td>
</tr>
<tr>
<td>• Endodontic services (Non-surgical) - pulp cap - vital pulpotomy⁴ - pulpal therapy⁴ - pulpal debridement⁴ - 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</td>
</tr>
<tr>
<td>• Endodontic Services [Surgical] - apicoectomy⁴ - retrograde filling⁴ - bone graft⁴ - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery⁴ - guided tissue regeneration⁴ - periradicular surgery⁴ - root amputation⁴ - hemisection⁴</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Coverage C – Complex Restorative Dentistry</th>
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<tbody>
<tr>
<td>• Pontics²</td>
</tr>
<tr>
<td>• Retainer (cast metal for resin bonded fixed prosthesis) one every five calendar years</td>
</tr>
<tr>
<td>• Inlays/onlays (used as abutments for fixed bridgework)²</td>
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<td>• Inlays/onlay restorations²</td>
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<td>• Sedative filling</td>
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<td>• Crowns²</td>
</tr>
<tr>
<td>• Permanent bridge installation one every five calendar years</td>
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<td>• Dentures – full and partial one every five calendar years</td>
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<td>• Denture adjustments after six months from the date of installation</td>
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<thead>
<tr>
<th>Coverage D – Orthodontic Dentistry</th>
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<tbody>
<tr>
<td>• Surgical access, exposure or immobilization (unerupted teeth)</td>
</tr>
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<td>• Placement of device to facilitate eruption (impacted teeth)</td>
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<td>• Diagnostic casts one every two calendar years</td>
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<td>• Orthodontic appliances (initial and subsequent installations)</td>
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<td>• Cephalometric x-rays</td>
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<tr>
<td>• Extractions</td>
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<tr>
<td>• Casts and models</td>
</tr>
</tbody>
</table>

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
DENTAL BENEFITS

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.

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

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

**Coverage A – Preventive and Diagnostic**

- Comprehensive and/or periodic oral exams
- Prophylaxis (cleaning, scaling and polishing)
- Sealants (permanent first or second molar teeth)(Covered Persons up to age 18) - supplement bitewings, including vertical bitewings one set of four every calendar year
- Pulp vitality tests
- Fluoride varnishes
- Topical fluoride (Covered Persons up to age 18)

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

- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicuspid (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

- Periodontics (Non-surgical)
  - periodontic cleanings four per calendar year
  - scaling and root planing four every two calendar years
  - periodontal evaluations
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement one every three calendar years

- Periodontics (Surgical)
  - gingivectomy
  - gingival flap procedures
  - osseous surgery, including flap entry and closure
  - osseous grafts
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures
  - free soft tissue grafts
  - connective tissue graft and double pedicle graft
  - bone graft
  - biologic materials to aid in soft and osseous tissue regeneration
  - distal or proximal wedge procedures

- Periodontic Services (Surgical) continued
  - soft tissue allografts
  - crown exposure
  - crown lengthening
  - General anesthetics (medically necessary)
  - Limited oral evaluation
  - Restorations one per tooth every two calendar years
  - Pin retention
  - Palliative treatment

- Tissue Allografts
  - 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
  - Temporary crown (within 72 hours of accident)
  - Endodontic services (Non-surgical)
  - pulp cap
  - vital pulpotomy
  - pulpal therapy
  - pulpal debridement
  - 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
  - apicification

- Endodontic Services (Surgical)
  - apicectomy
  - retrograde filling
  - bone graft
  - biologic materials to aid in soft/osseous tissue regeneration in connection with periapical surgery
  - guided tissue regeneration
  - periapical surgery
  - root amputation
  - hemisection

- Denture adjustments after six months from the date of installation
- Denture relining one every three calendar years
- Post and core
- Coro buildup

### Coverage C – Complex Restorative Dentistry

- Crowns
- Inlays/onlays (used as abutments for fixed bridgework)
- Inlays/onlays restorations
- Porcelain
- Porcelain veneers
- Porcelain crowns
- Porcelain bridges
- Porcelain/ceramic inlay/onlay restorations
- Porcelain/ceramic crowns
- Porcelain/ceramic fixed bridgework
- Porcelain/ceramic implant crowns
- Porcelain/ceramic implant bridgework
- Porcelain/ceramic post and core
- Porcelain/ceramic post and core restorations
- Porcelain/ceramic post and core bridges
- Porcelain/ceramic post and core implant crowns
- Porcelain/ceramic post and core implant bridgework
- Porcelain/ceramic post and core implant crown bridges

### Coverage D – Orthodontic Dentistry (NOT COVERED)

- Orthodontic appliances (initial and subsequent installations)
- Cephalometric x-rays
- Extraction
- Casts and models

1. **two** every calendar year
2. **one** per tooth every five calendar years
3. **four** every five calendar years
4. **one** per tooth while covered under the Plan
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, investigatory, 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.

Please note: If you cancel dental coverage, you and your eligible dependents may re-enroll during the EHA’s annual renewal month (September). Dental benefits will be limited to Coverage A for the first year following re-enrollment. Premiums will not be reduced.

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.

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.

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.