## Schedule of Benefits Summary – Option 2

**Group Name:** Educators Health Alliance  
**Effective Date:** September 01, 2020

<table>
<thead>
<tr>
<th>Payment for Services</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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, C Services</td>
<td>B, C Services</td>
</tr>
<tr>
<td><strong>COVERAGE FOR DENTAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Coinsurance shown below is the percentage the Covered Person must pay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage A</strong> (Preventive and Diagnostic)</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Coverage B</strong> (Maintenance, Simple Restorative, Oral Surgery, Periodontics and Endodontics)</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Coverage C</strong> (Complex Restorative)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Coverage D</strong> (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 For Dental Services**

### Coverage A – Preventive and Diagnostic

- Comprehensive and/or periodic oral exams<sup>1</sup>
- Prophylaxis (cleaning, scaling and polishing)<sup>1</sup>
- Sealants (permanent first or second molar teeth) **(Covered Persons up to age 16)**
  - once every four calendar years
- Pulp vitality tests
- Fluoride varnishes<sup>1</sup>
- Topical fluoride **(Covered Persons up to age 16)**<sup>3</sup>

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

- **Oral surgery consisting of:**
  - simple extractions, including root removal 1<sup>st</sup> and 2<sup>nd</sup> bicuspids (orthodontic extractions are not covered)
  - impacted extractions
  - transseptal fibromyoplasty/supra crestal fiberotomy
  - bone replacement graft
  - appliance removal not by dentist who placed device
  - oorotial 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
  - 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 grafts<sup>3</sup>
  - connective tissue graft and double pedicle graft<sup>3</sup>
  - bone graft<sup>4</sup>
  - biologic materials to aid in soft and osseous tissue regeneration<sup>3</sup>
  - distal or proximal wedge procedures<sup>3</sup>

### Coverage C – Complex Restorative Dentistry

- Pontics<sup>2</sup>
- Retainer (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
- Crowns<sup>2</sup>
- 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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<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

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