SignatureBlue

Dental Benefit Solutions

BlueCross BlueShield Nebraska

Schedule of Benefits Summary — Non-Standard Option 3 Premier

Group Name: Nebraska Association of County Officials — Effective Date: July 01, 2024

Payment for Services	In-Network Provider	Out-of-Network Provider
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.		
Deductible (the amount the Covered Person pays each Calendar Year for combined Covered Services before the Coinsurance is payable) • Individual • Family Calendar Year Deductible applies to the following Coverage benefits:	 **$50** **$150** **B, C Services**	 **$100** **$300** **B, C Services**
Calendar Year Maximum Benefit (the calendar year amount payable for combined Covered Services for each Covered Person while covered under this plan) Calendar Year Maximum Benefit applies to the following Coverage benefits:	**$2,000** **A, B, C Services**	**$2,000** **A, B, C Services**
Total Maximum Benefit (the total amount payable for Covered Services for each Covered Person) Total Maximum Benefit applies to the following Coverage benefits	**$1,500** **D Services**	**$1,500** **D Services**
COVERAGE FOR DENTAL SERVICES (Coinsurance shown below is the percentage the Covered Person must pay)		
Coverage A (Preventive and Diagnostic)	**0%**	**40%**
Coverage B (Maintenance, Simple Restorative, Oral Surgery, Periodontics and Endodontics)	**20%**	**50%**
Coverage C (Complex Restorative)	**50%**	**50%**
Coverage D (Orthodontic Dentistry) • Eligible Dependents up to Age 19 • All other covered persons	 **50%** **Not Covered**	 **50%** **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, 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 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)**
- **Diagnostic casts**
  one every two calendar years
- **Placement of device to facilitate eruption (impacted teeth)**
- **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*