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

Voluntary Dental

Summary of Benefits for Inventive, LLC dba In the Ditch Towing Products #10036043	**Voluntary Dental Option A**	
Individual Deductible **Family Deductible** (The Family Deductible is satisfied after three (3) Insureds of the same family have met their Individual Deductible.) (Deductible applies to In-Network basic and major services and all Out-of-Network services.)	$25 In-Network/$50 Out-of-Network 3 Family Maximum/3 Family Maximum	
Annual Individual Maximum Benefit	$1,000	
	In-Network	**Out-of-Network**
In/Out-of-Network	By choosing an In-Network provider you pay only coinsurance and/or copayment amounts for allowed charges.	By choosing an Out-of-Network provider you pay your deductible, coinsurance, and are responsible for the difference between what Blue Cross allows and what the Out-of-Network provider charges.
Preventive Services		
Oral Examinations One examination every six months.	You pay $20 copayment	By choosing an Out-of-Network provider you pay 30% of the allowed amount*
Complete Mouth Series or Panoramic X-Ray Limited to one time in any five consecutive Benefit Periods.		
Bitewing X-Rays Limited to once per Benefit Period.		
Dental Prophylaxis Limited to one prophylaxis every six months (Regardless of type)		
Fluoride Treatments Limited to one (1) application per benefit period and limited to insured's who are under age twenty-six (26).		
Basic Services 6 month waiting period applies		
Sealants Limited to permanent posterior unrestored dentition of insured's under age sixteen. Also limited to one time per tooth in any three consecutive Benefit Periods.	You pay 20% of the allowed amount	By choosing an Out-of-Network provider you pay 50% of the allowed amount*
Fillings Same tooth surface restoration is covered once in a two (2) year period.		
Extractions		
Major Services Predetermination required on all major services, 12 month waiting period applies		
General Anesthesia/I.V. Sedation	You pay 50% of the allowed amount	By choosing an Out-of-Network provider you pay 60% of the allowed amount*
Root Canal Therapy		
Scaling and Root Planning Limited to once per quadrant of the mouth, every three Benefit Periods.		
Periodontal Maintenance Limited to once in a six (6) month period. (Regardless of type)		
Inlays, Onlays, Crowns, Dentures, Bridges, and Veneers Limited to every five years.		
Dental Implants Including the implant body, implant abutment and implant crown – benefits may be available up to the Maximum Allowance of a standard complete or partial denture, or bridge. Implant body and abutment-limited to once per tooth per lifetime. Implant crown –five year replacement.		

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***By choosing an Out-of-Network provider you pay your coinsurance, deductible, and any difference between what Blue Cross of Idaho allows and what the Out-of-Network provider charges.**

This summary describes the general features of this program; it is not a contract. All provisions of the Group Master Policy apply to this program.

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Policy, the following exclusions and limitations apply to the entire policy, unless otherwise specified.

- Procedures that are not included in the Closed List of Dental Covered Services; or that are not Medically Necessary for the care of an Insured's covered dental condition; or that do not have uniform professional endorsement.
- Charges for services that were started prior to the Insured's Effective Date. The following guidelines will be used to determine the date when a service is deemed to have been started:
  - For full dentures or partial dentures: on the date the final impression is taken.
  - For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared.
  - For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex.
  - For periodontal Surgery: on the date the Surgery is actually performed.
  - For all other services: on the date the service is performed.
  - For orthodontic services, if benefits are available under this Policy: on the date any bands or other appliances are first inserted.
- Cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgam or composite fillings).
- Replacement of an existing crown, inlay or onlay that was installed within the preceding five (5) years or replacement of an existing crown, inlay or onlay that can be repaired.
- Appliances, restorations or other services provided or performed solely to change, maintain or restore vertical dimension or occlusion.
- A service for cosmetic purposes, unless necessitated as a result of Accidental Injuries received while the Insured was covered by BCI.
- In excess of the Maximum Allowance.
- A partial or full removable denture for fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding five (5) years.
- Orthodontic services and supplies unless otherwise specifically listed in the Closed List of Dental Covered Services.
- Repair of appliances or replacement of lost or stolen appliances.
- Ridge augmentation procedures.
- Any procedure, service or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla or mandible for a prosthetic appliance. Excluded services include, but are not limited to, vestibuloplasty, stomatoplasty and bone grafts (either synthetic or autogenous) to the alveolars, maxilla or mandible.
- Any procedure, service or supply required directly or indirectly to treat a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.
- Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.
- Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable.
- Any service, procedure or supply for which the prognosis for success is not reasonably favorable as determined by BCI.
- Myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures; charges for acid etching; or charges for oral cancer screenings which are included in a regular oral examination.
- For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures.
- Diagnostic casts.
- Occlusal adjustments.
- Not prescribed by or upon the direction of a Provider.
- Investigational in nature;
- Provided for any condition, Disease, Illness or Accidental Injury to the extent thatThe Insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party.
- Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage u nder this Policy; or for which payment has been made under Medicare Part A and/or Medicare Part B or would have been made if an Insured had applied for such payment except when payment under this Policy is expressly required by federal law.
- Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.
- Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- For personal hygiene, comfort, beautification or convenience items even if prescribed by a Dentist, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs.
- For telephone consultations; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Dentist or other Provider.
- For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.
- For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation.
- For treatment or other health care of any Insured in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Insured to Covered Services under this Policy, if and to the extent those benefits are payable to or due the Insured under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's or other similar policy of insurance, contract or underwriting plan;
- In the event Blue Cross of Idaho for any reason makes payment for or otherwise provides benefits excluded by this provision, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Insured, and the Insured's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Insured or his or her estate for such services, supplies, drugs or other charges so provided by Blue Cross of Idaho in connection with such Illness, Disease, Accidental Injury or other condition.
- Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.
- Provided to persons who were enrolled as Eligible Dependents after they cease to qualify as Eligible Dependents due to a change in Eligibility status which occurs during the Policy term.
- Provided outside the United States, which if had been provided in the United States, would not be Covered Services under this Policy.
- Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.
- For acupuncture or hypnosis.
- Occlusal x-rays.
- Extraoral x-rays.
- Other x-rays not specifically listed as a Covered Service in this Policy.
- Space maintainers.
- Palliative treatment.
- Biopsy of soft or hard oral tissue.
- Pin retention.
- Excision of pericoronal tissues.
- Root recovery.
- Tooth reimplantation
- Tooth transplantation.
- Alveoloplasty and alveolectomy.
- Removal of exostosis.
- Frenectomy (frenulectomy)
- Excision of hyperplastic tissue.
- No benefits are available for replacement and/or repair of orthodontic appliances. This includes removable and/or fixed retainers.