Schedule of Dental Benefits

Pediatric Essential Benefits

This is the *Schedule of Dental Benefits* that is a part of your Dental Blue Pediatric Essential Benefits Plan. This schedule describes the dental services that are covered by your dental plan for *members* who are eligible for pediatric essential dental benefits. It also shows the cost-sharing amounts you must pay for these *covered services*. Do not rely on this schedule alone. **You should read all parts of your dental plan benefit booklet to become familiar with the key points. Be sure to read the descriptions of *covered services* and the limitations and exclusions.** You should keep your dental plan handy so that you can refer to it. The words that are shown in italics have special meanings. These words are explained in Part 7 of your benefit booklet.

Who Is Eligible for Pediatric Essential Dental Benefits

The dental benefits described in this dental plan are provided for a *member* only until the end of the calendar month in which the *member* turns age 19 (or as required by federal law).

Annual Deductible

Your *deductible* each *plan year*:	$50 per eligible *member* (no more than $150 for three or more *members* who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership)

The *deductible* is the cost you have to pay during the annual coverage period (as shown above) before benefits will be paid. The *deductible* applies to Group 2 and Group 3 services only. A *deductible* does not apply to Group 1 services or to Orthodontic Services. See the chart that starts on the next page for how much you pay for *covered services* you receive after you meet the *deductible* (when it applies).

Annual Out-of-Pocket Maximum

Your *out-of-pocket maximum* each *plan year*:	$350 per *member* (no more than $700 for two or more *members* who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership)

Your *out-of-pocket maximum* is the most you could pay during the annual coverage period (as shown above) for your share of the costs for *covered services*—your cost-sharing amounts. This *out-of-pocket maximum* helps you plan for health care expenses. Even though you pay the following costs, they do not count toward your *out-of-pocket maximum*: costs for your dental plan; any *balance-billed* charges; all dental services for *members* who are not eligible for pediatric essential dental benefits; and all services this dental plan does not cover.

Annual Overall Benefit Limit for What the Plan Pays

Your overall benefit limit:	None

You do not have an overall benefit limit for pediatric essential dental benefits. But, there are limits that apply for specific *covered services*, such as for periodic oral exams. Some of these limits are described in this *Schedule of Dental Benefits* in the chart that starts below. **Do not rely on this chart alone.** Your dental plan fully describes all of the limits and exclusions that apply for your dental benefits. Be sure to read all parts of your dental plan.

What You Pay for Covered Dental Services—Your Cost-Sharing Amounts

You should be sure to read all parts of your dental plan to understand the requirements that you must follow to receive all of your dental benefits. You will receive these dental benefits as long as:

- You are a *member* who is eligible to receive pediatric essential dental benefits.
- Your dental service is a *covered service* as described in this dental plan benefit booklet and *Schedule of Dental Benefits*.
- Your dental service is *necessary and appropriate* as determined by *Blue Cross and Blue Shield*.
- Your dental service conforms to *Blue Cross and Blue Shield* dental guidelines and *utilization review*.
- You use a *participating dentist* to get a *covered service*, except as noted in this dental plan.

Covered Services		Your Cost Is:
Group 1— Preventive Services and Diagnostic Services		No charge
Oral exams	• One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures) • Periodic or routine oral exams; twice in a calendar year • Oral exams for a *member* under age three; twice in a calendar year • Limited oral exams; twice in a calendar year	
X-rays	• Single tooth x-rays; no more than one per visit • Bitewing x-rays; twice in a calendar year • Full mouth x-rays; once in three calendar years per provider or location • Panoramic x-rays; once in three calendar years per provider or location	
Routine dental care	• Routine cleaning, minor scaling, and polishing of the teeth; twice in a calendar year • Fluoride treatments; once in 90 days • Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered) • Space maintainers	
Group 2—Basic Restorative Services		25% *coinsurance* after *deductible*
Fillings	• Amalgam (silver) fillings; one filling per tooth surface in 12 months • Composite resin (white) fillings; one filling per tooth surface in 12 months	

Covered Services		Your Cost Is:
Group 2—Basic Restorative Services (continued)		25% *coinsurance* after *deductible*
Root canal treatment	• Root canals on permanent teeth; once per tooth • Vital pulpotomy • Retreatment of prior root canal on permanent teeth; once per tooth in 24 months • Root end surgery on permanent teeth; once per tooth	
Crowns (see also Group 3)	• Prefabricated stainless steel crowns; once per tooth (primary and permanent)	
Gum treatment	• Periodontal scaling and root planing; once per quadrant in 36 months • Periodontal surgery; once per quadrant in 36 months	
Prosthetic maintenance	• Repair of partial or complete dentures and bridges; once in 12 months • Reline or rebase partial or complete dentures; once in 24 months • Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth	
Oral surgery	• Simple tooth extractions; once per tooth • Erupted or exposed root removal; once per tooth • Surgical extractions; once per tooth (approval required for complete, boney impactions) • Other necessary oral surgery	
Other necessary services	• Dental care to relieve pain (palliative care) • General anesthesia for covered oral surgery	
Group 3—Major Restorative Services		50% *coinsurance* after *deductible*
Crowns	• Resin crowns; once per tooth in 60 months • Porcelain/ceramic crowns; once per tooth in 60 months • Porcelain fused to metal/high noble crowns; once per tooth in 60 months	
Tooth replacement	• Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months • Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months	
Other necessary services	• Occlusal guards when necessary; once in calendar year • Fabrication of an athletic mouth guard	
Orthodontic Services		50% *coinsurance*
Medically necessary orthodontic care that has been preauthorized for a qualified *member*	• Braces for a *member* who has a severe and handicapping malocclusion • Related orthodontic services for a *member* who qualifies	