

## Schedule of Dental Benefits

### Essential Dental Benefits for Members Under Age 19

This is the *Schedule of Dental Benefits* that is a part of your Dental Blue Policy. This schedule describes the dental services that are covered by your Dental Blue Policy for *members* who are under age 19. 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 Blue Policy 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 Blue Policy and this *Schedule of Dental Benefits* handy so that you can refer to them. The words that are shown in italics have special meanings. These words are explained in Part 8 of your Dental Blue Policy.

#### Who Is Eligible for Dental Benefits—Members Under Age 19

The dental benefits described in this *Schedule of Dental Benefits* are limited to *members* who are under age 19 (from birth through age 18).

#### Annual Deductible

Your <i>deductible</i> each <i>plan year</i> :	\$50 per <i>member</i> (no more than \$150 for three or more <i>members</i> under age 19 enrolled under the same family membership)
--	---

The *deductible* is the cost you have to pay during the annual coverage period (as shown above) for Group 2 and Group 3 services before benefits will be paid. This *deductible* does not apply for Group 1 and 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*.

#### Annual Out-of-Pocket Maximum

Your <i>out-of-pocket maximum</i> each <i>plan year</i> :	\$350 per <i>member</i> (no more than \$700 for two or more <i>members</i> under age 19 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*: your *premiums*; any *balance-billed* charges; all costs for dental services for *members* age 19 or older; and all services this Dental Blue Policy 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 what this Dental Blue Policy covers. 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 on the next page. **Do not rely on this chart alone.** Your Dental Blue Policy fully describes all of the limits and exclusions that apply for your dental benefits. Be sure to read all parts of your Dental Blue Policy.

## Schedule of Dental Benefits (continued)

### Essential Dental Benefits for Members Under Age 19

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

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

- You are a *member* who is under age 19 and eligible to receive these dental benefits.
- Your dental service is a *covered service* as described in your Dental Blue Policy and this *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*. (The only exceptions are noted in your Dental Blue Policy.)

Covered Services for Members Under Age 19		Your Cost Is:
<b>Group 1— Preventive Services and Diagnostic Services</b>		No charge
Oral exams	<ul style="list-style-type: none"> <li>• One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures)</li> <li>• Periodic or routine oral exams; twice in 12 months</li> <li>• Oral exams for a <i>member</i> under age three; twice in 12 months</li> <li>• Limited oral exams; twice in 12 months</li> </ul>	
X-rays	<ul style="list-style-type: none"> <li>• Single tooth x-rays; no more than one per visit</li> <li>• Bitewing x-rays; twice in 12 months</li> <li>• Full mouth x-rays; once in 36 months per provider or location</li> <li>• Panoramic x-rays; once in 36 months per provider or location</li> </ul>	
Routine dental care	<ul style="list-style-type: none"> <li>• Routine cleaning, minor scaling, and polishing of the teeth; twice in 12 months</li> <li>• Fluoride treatments; once per calendar quarter</li> <li>• Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered)</li> <li>• Space maintainers</li> </ul>	
<b>Group 2—Basic Restorative Services</b>		25% <i>coinsurance</i> after <i>deductible</i>
Fillings	<ul style="list-style-type: none"> <li>• Amalgam (silver) fillings; one filling per tooth surface in 12 months</li> <li>• Composite resin (white) fillings; one filling per tooth surface in 12 months (for primary back teeth, payment for a composite filling will not be more than the amount allowed for an amalgam filling)</li> </ul>	
Root canal treatment	<ul style="list-style-type: none"> <li>• Root canals on permanent teeth; once per tooth</li> <li>• Vital pulpotomy</li> <li>• Retreatment of prior root canal on permanent teeth; once per tooth in 24 months</li> <li>• Root end surgery on permanent teeth; once per tooth</li> </ul>	

## Schedule of Dental Benefits (continued)

### Essential Dental Benefits for Members Under Age 19

Covered Services for Members Under Age 19		Your Cost Is:
<b>Group 2—Basic Restorative Services</b> (continued)		25% <i>coinsurance</i> after <i>deductible</i>
Crowns (see also Group 3)	<ul style="list-style-type: none"> <li>• Prefabricated stainless steel crowns; once per tooth (primary and permanent)</li> </ul>	
Gum treatment	<ul style="list-style-type: none"> <li>• Periodontal scaling and root planing; once per quadrant in 36 months</li> <li>• Periodontal surgery; once per quadrant in 36 months</li> </ul>	
Prosthetic maintenance	<ul style="list-style-type: none"> <li>• Repair of partial or complete dentures and bridges; once in 12 months</li> <li>• Reline or rebase partial or complete dentures; once in 24 months</li> <li>• Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth</li> </ul>	
Oral surgery	<ul style="list-style-type: none"> <li>• Simple tooth extractions; once per tooth</li> <li>• Erupted or exposed root removal; once per tooth</li> <li>• Surgical extractions; once per tooth (approval required for complete, boney impactions)</li> <li>• Other necessary oral surgery</li> </ul>	
Other necessary services	<ul style="list-style-type: none"> <li>• Dental care to relieve pain (palliative care)</li> <li>• General anesthesia for covered oral surgery</li> </ul>	
<b>Group 3—Major Restorative Services</b>		
Crowns	<ul style="list-style-type: none"> <li>• Resin crowns; once per tooth in 60 months</li> <li>• Porcelain/ceramic crowns; once per tooth in 60 months</li> <li>• Porcelain fused to metal/high noble crowns; once per tooth in 60 months</li> </ul>	
Tooth replacement	<ul style="list-style-type: none"> <li>• Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months</li> <li>• Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months</li> </ul>	
Other necessary services	<ul style="list-style-type: none"> <li>• Occlusal guards when necessary; once in calendar year</li> <li>• Fabrication of an athletic mouth guard</li> </ul>	
<b>Orthodontic Services</b>		50% <i>coinsurance</i>
Medically necessary orthodontic care that has been preauthorized for a qualified <i>member</i>	<ul style="list-style-type: none"> <li>• Braces for a <i>member</i> who has a severe and handicapping malocclusion</li> <li>• Related orthodontic services for a <i>member</i> who qualifies</li> </ul>	