SECTION XVVI

EssentialSmile Ped 111, ST, INN, Pediatric Dental

SCHEDULE OF BENEFITS

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT			
Deductible • One (1) Member under age 19 • Two (2) or more Members under age 19	$50 $50 per member	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Out-of-Pocket Limit • One (1) Member under age 19 • Two (2) or more Members under age 19	$350 $700		
Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.			

PEDIATRIC DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Emergency Dental Care	$10 Copayment After Deductible	Non-Participating Provider Services Are Not Covered You Pay the Full Cost	One (1) dental exam & cleaning per six (6) month period Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X-rays at six month intervals
• Preventive Dental Care	$0 - $125 Copayment After Deductible		
• Routine Dental Care	$0 - $100 Copayment After Deductible		
• Endodontics	$30 - $350 Copayment After Deductible		
• Periodontics	$51 - $133 Copayment After Deductible		
• Prosthodontics	$20 - $350 Copayment After Deductible		
• Oral Surgery	$60 - $306 Copayment After Deductible		
• Orthodontics	$350 Copayment After Deductible		
Preauthorization	**Treatment of Malignancies, Cysts, or Neoplasms, General Anesthesia, IV Sedation, Crowns, Bridges, Prosthetics, and Specialist Care Require Preauthorization**		

The Copayments listed in the Schedule of Benefits are for Covered Services provided by a Participating Provider who is a General Dentist.

CODE	DESCRIPTION	MEMBER COST-SHARING	LIMITATIONS
PREVENTIVE DENTAL CARE			
D1110	Prophylaxis - adult	$0	Six (6) month intervals
D1120	Prophylaxis - child	$0	Six (6) month intervals
D1206	Topical application of fluoride varnish	$30	Six (6) month intervals where the local water supply is not fluoridated
D1208	Topical application of fluoride - excluding varnish	$30	Six (6) month intervals where the local water supply is not fluoridated
D1351	Sealant - per tooth	$0	One (1) time in any thirty-six (36) consecutive month per tooth
D1510	Space maintainer - fixed - unilateral	$50	
D1515	Space maintainer - fixed - bilateral	$100	
D1520	Space maintainer - removable - unilateral	$75	
D1525	Space maintainer - removable - bilateral	$125	
D1550	Re-cement or re-bond space maintainer	$20	
D1555	Removal of fixed space maintainer	$20	
D8210	Removable appliance therapy	$100	
ROUTINE DENTAL CARE - APPOINTMENTS			
D0120	Periodic oral evaluation - established patient	$0	Once within a six (6) month consecutive period
D0140	Limited oral evaluation - problem focused	$0	
D0145	Oral evaluation for a patient under 3 years of age	$0	Once within a six (6) month consecutive period
D0150	Comprehensive oral evaluation - new or established patient	$0	Once within a thirty-six (36) consecutive month period
D0160	Detailed and extensive oral evaluation - problem focused	$0	Once within a six (6) month consecutive period
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10	For Emergency Dental
ROUTINE DENTAL CARE - RADIOGRAPHY / DIAGNOSTIC DENTISTRY			
D0210	Intraoral - complete series of radiographic images	$0	Thirty-six (36) month intervals
D0220	Intraoral - periapical first radiographic image	$0	
D0270	Bitewing - single radiographic image	$0	Six (6) month intervals
D0272	Bitewings - 2 radiographic images	$0	Six (6)month intervals

CODE	DESCRIPTION	MEMBER COST-SHARING	LIMITATIONS
ROUTINE DENTAL CARE - RADIOGRAPHY / DIAGNOSTIC DENTISTRY CONT.			
D0273	Bitewings - 3 radiographic images	$0	Six (6)month intervals
D0274	Bitewings - 4 radiographic images	$0	Six (6)month intervals
D0330	Panoramic radiographic image	$0	Thirty-six (36) month intervals
ROUTINE DENTAL CARE - RESTORATIVE DENTISTRY			
D2140	Amalgam - one surface, primary or permanent	$25	
D2150	Amalgam - two surfaces, primary or permanent	$40	
D2160	Amalgam - three surfaces, primary or permanent	$50	
D2161	Amalgam - four or more surfaces, primary or permanent	$65	
D2330	Resin-based composite - one surface, anterior	$50	
D2331	Resin-based composite - two surfaces, anterior	$60	
D2332	Resin-based composite - three surfaces, anterior	$80	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$100	
D2930	Prefabricated stainless steel crown - primary tooth	$75	Limited to one (1) per tooth per consecutive sixty (60) months
D2931	Prefabricated stainless steel crown - permanent tooth	$75	Limited to one (1) per tooth per consecutive sixty (60) months
D2940	Protective restoration	$10	
ROUTINE DENTAL CARE - ORAL SURGERY			
D7111	Extraction, coronal remnants - deciduous tooth	$60	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$70	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$132	
D7220	Removal of impacted tooth – soft tissue	$177	
D7230	Removal of impacted tooth – partially bony	$229	
D7240	Removal of impacted tooth – completely bony	$281	
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$306	
D7250	Surgical removal of residual tooth roots (cutting procedure)	$127	
D7251	Coronectomy – intentional partial tooth removal	$270	
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$200	
D7272	Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)	$100	
D7280	Surgical access of an unerupted tooth	$220	
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$196	
D7283	Placement of device to facilitate eruption of impacted tooth	$80	

CODE	DESCRIPTION	MEMBER COST-SHARING	LIMITATIONS
ROUTINE DENTAL CARE - ORAL SURGERY CONT.			
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$175	
D7963	Frenuloplasty	$125	
ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$30	
D3120	Pulp cap - indirect (excluding final restoration)	$30	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$70	
D3221	Pulpal debridement, primary and permanent teeth	$90	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$70	
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$60	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$350	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$350	
D3330	Endodontic therapy, molar (excluding final restoration)	$350	
D3331	Treatment of root canal obstruction; non-surgical access	$85	
D3332	Incomplete Endodontic therapy; inoperable, unrestorable or fractured tooth	$75	
D3333	Internal root repair of perforation defects	$115	
D3346	Retreatment of previous root canal therapy - anterior	$100	
D3347	Retreatment of previous root canal therapy - bicuspid	$100	
D3348	Retreatment of previous root canal therapy - molar	$100	
D3421	Apicoectomy - bicuspid (first root)	$50	
D3425	Apicoectomy - molar (first root)	$50	
D3426	Apicoectomy (each add root)	$50	
D3430	Retrograde filling - per root	$65	
D3450	Root amputation - per root	$225	
PERIODONTICS			
D4341	Periodontal scaling & root planing - four or more teeth per quadrant	$133	Limited (1) per quadrant per 24 months
D4342	Periodontal scaling & root planing - one to three teeth per quadrant	$51	Limited (1) per quadrant per 24 months

CODE	DESCRIPTION	MEMBER COST-SHARING	LIMITATIONS
PERIODONTICS CONT.			
D4910	Periodontal maintenance	$74	Once within a six (6) month consecutive period
PROSTHODONTICS - REMOVABLE			
D5110	Complete denture - maxillary	$350	Limited to one (1) per consecutive sixty (60) months
D5120	Complete denture - mandibular	$350	Limited to one (1) per consecutive sixty (60) months
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$350	Limited to one (1) per consecutive sixty (60) months
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$350	Limited to one (1) per consecutive sixty (60) months
D5410	Adjust complete denture - maxillary	$20	
D5411	Adjust complete denture - mandibular	$20	
D5421	Adjust partial denture - maxillary	$20	
D5422	Adjust partial denture - mandibular	$20	
D5510	Repair broken complete denture base	$120	
D5520	Replace missing or broken teeth - complete denture (each tooth)	$125	
D5610	Repair resin denture base	$120	
D5620	Repair cast framework	$130	
D5630	Repair or replace broken clasp	$130	
D5640	Replace broken teeth - per tooth	$115	
D5710	Rebase complete maxillary denture	$175	
D5711	Rebase complete mandibular denture	$175	
D5720	Rebase maxillary partial denture	$170	
D5721	Rebase mandibular partial denture	$170	
D5730	Reline complete maxillary denture (chairside)	$135	
D5731	Reline complete mandibular denture (chairside)	$135	
D5740	Reline maxillary partial denture (chairside)	$135	
D5741	Reline mandibular partial denture (chairside)	$135	
D5750	Reline complete maxillary denture (laboratory)	$165	
D5751	Reline complete mandibular denture (laboratory)	$165	
D5760	Reline maxillary partial denture (laboratory)	$165	
D5761	Reline mandibular partial denture (laboratory)	$165	
PROSTHODONTICS - FIXED			
D6211	Pontic - cast predominantly base metal	$350	Limited to one (1) per tooth per consecutive sixty (60) months
D6251	Pontic - resin with predominantly base metal	$350	Limited to one (1) per tooth per consecutive sixty (60) months

CODE	DESCRIPTION	MEMBER COST-SHARING	LIMITATIONS
PROSTHODONTICS - FIXED CONT.			
D6721	Crown - resin with predominantly base metal	$350	Limited to one (1) per tooth per consecutive sixty (60) months
D6791	Crown - full cast predominantly base metal	$350	Limited to one (1) per tooth per consecutive sixty (60) months
ORTHODONTIA **Orthodontic treatment is Medically Necessary only and limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.**			
D8050	Interceptive orthodontic treatment of the primary dentition	$350	
D8060	Interceptive orthodontic treatment of the transitional dentition	$350	
D8070	Comprehensive orthodontic treatment of the transitional dentition	$350	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$350	
MISCELLANEOUS SERVICES			
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$50	