



SECTION XXVI.

**EssentialSmile Ped 112, ST, INN, Pediatric Dental
SCHEDULE OF BENEFITS**

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
<p>PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT</p> <p>Deductible</p> <ul style="list-style-type: none"> • One (1) Member under age 19 • Two (2) or more Members under age 19 <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • One (1) Member under age 19 • Two (2) or more Members under age 19 <p>Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.</p>	<p>\$50</p> <p>\$50 per member</p> <p>\$350</p> <p>\$700</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	

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Underwritten by Solstice Health Insurance Company, a licensed Accident and Health Insurance Company under New York Insurance Law Section 1113(a)(3)



PEDIATRIC DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> • Emergency Dental Care • Preventive Dental Care • Routine Dental Care • Endodontics • Periodontics • Prosthodontics • Oral Surgery • Orthodontics 	<p>\$10 Copayment After Deductible</p> <p>\$0 - \$125 Copayment After Deductible</p> <p>\$0 - \$100 Copayment After Deductible</p> <p>\$30 - \$350 Copayment After Deductible</p> <p>\$51 - \$133 Copayment After Deductible</p> <p>\$20 - \$350 Copayment After Deductible</p> <p>\$60 - \$306 Copayment After Deductible</p> <p>\$350 Copayment After Deductible</p>	<p>Non-Participating Provider Services Are Not Covered You Pay the Full Cost</p>	<p>One (1) dental exam & cleaning per six (6) month period</p> <p>Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X-rays at six month intervals</p>
<p>Preauthorization</p>	<p>Treatment of Malignancies, Cysts, or Neoplasms, General Anesthesia, IV Sedation, Crowns, Bridges, Prosthetics, and Specialist Care Require Preauthorization</p>		

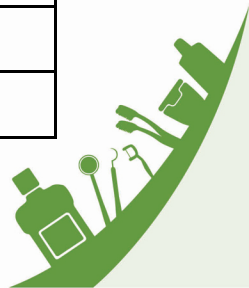


The Copayments listed in the Schedule of Benefits are for Covered Services provided by a Participating Provider who is a General Dentist.

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	

