DentalEssentials

Schedule of Benefits Summary

Premier (with waiting period)

Payment for Services	In-Network Provider	Out-of-Network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In -network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered Services, which are the Covered Person's responsibility. That means In-network Providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. In some situations, Out-of-network Providers can bill for amounts over the Out-of-network Allowance.		
Deductible (the amount the Covered Person pays each Calendar Year for combined Covered Services before the Coinsurance is payable) • Individual Calendar Year Deductible applies to the following Coverage benefits**:**	**$100** **B, C Services**	**$100** **A, B, C Services**
Calendar Year Maximum Benefit (the calendar year amount payable for combined Covered Services for each Covered Person while covered under this plan) Calendar Year Maximum Benefit applies to the following Coverage benefits:	**$2,000** **A, B, C Services**	**$2,000** **A, B, C Services**
COVERAGE FOR DENTAL SERVICES (Coinsurance shown below is the percentage the Covered Person must pay)		
Coverage A (Preventive and Diagnostic)	**0%**	**20%**
Coverage B (Maintenance, Simple Restorative and Oral Surgery)	**20%**	**30%**
Coverage C (Complex Restorative, Periodontics and Endodontics)	**50%**	**50%**
Coverage D (Orthodontic Dentistry)	**Not Covered**	**Not Covered**
WAITING PERIOD		
Coverage A	**None**	**None**
Coverage B	**6 Months**	**6 Months**
Coverage C	**12 Months**	**12 Months**

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Coverage for Dental Services

Coverage A – Preventive and Diagnostic

- **Comprehensive and/or periodic oral exams**
  two every calendar year
- **Consultations (medical necessary)**
- **Prophylaxis (cleaning, scaling and polishing)**
  two every calendar year
- **Topical fluoride**
  two every calendar year for Covered Persons up to age 16
- **Fluoride varnishes**
  two every calendar year
- **Sealants (permanent first or second molar teeth**)
  once every four calendar years for Covered Persons up to age 16
- **Pulp vitality tests**
- **Space maintainers (prematurely lost primary teeth)** *for Covered Persons up to age 16*
- **X-rays (intraoral, bitewing, occlusal, periapical, extraoral)**
  - full mouth or panorex series
    one every three consecutive calendar years
  - supplemental bitewing
    one set of four every calendar year

Coverage B – Maintenance, Simple Restorative and Oral Surgery

- **Oral surgery consisting of:**
  - simple and impacted extractions (orthodontic extractions are not covered)
  - alveoloplasty
  - removal of dental cysts and tumors
  - surgical incision and drainage of dental abscess
  - TMJ reduction (of a complete dislocation or fracture resulting from an accidental injury and provided within 12 months of the injury)
  - tooth replantation
  - excision of hyperplastic tissue
- **General anesthesia (medically necessary)**
- **Restorations**
  one per tooth every two calendar years
- **Temporary crown (within 72 hours of accident)**
- **Palliative treatment**
- **Dry socket treatment**
- **Emergency oral examinations**

Coverage C – Periodontal, Endodontics and Complex Restorative Dentistry

- **Periodontic Services (treatment of diseases of gums and supporting tooth structure)**
  - periodontic cleanings
    four per calendar year
  - gingivectomy and gingival curettage
  - osseous surgery, including flap entry and closure
  - osseous graft
  - scaling and root planing
  - provisional or permanent periodontal splinting
  - mucogingivoplastic surgery
  - treatment of acute infection and oral lesions
  - full mouth debridement
- **Endodontic Services (treatment of diseases or injuries of pulp chambers, root canals and periapical tissue)**
  - pulp cap
  - vital pulpotomy
  - root canal therapy (includes treatment plan x-rays, clinical procedures and follow-up care)
  - apical curettage
  - root resection and hemisection
- **Pre-formed stainless steel or acrylic crowns**
- **Recement inlays and crowns**
- **Crowns and labial veneers**
  one per tooth every five calendar years
- **Inlays when used as abutments for fixed bridgework**
- **Installation of permanent bridges**
  one every five calendar years
- **Dentures – full and partial**
  o*ne every five calendar years*
- **Repair of dentures, bridges, crowns and cast restorations**
- **Denture relining**
  one every 36-consecutive months
- **Denture adjustments**
  after six months from the date of installation
- **Core buildup**
- **Cast post and core in addition to crown**