Colorado Essential Health Benefit for Children

**Smile for Kids LOW EHB**

This summary of benefits, along with the exclusions and limitations describe the benefits of the Essential Health Benefit (EHB) for Children. Please review closely to understand all benefits, exclusions and limitations.

<table>
<thead>
<tr>
<th>Child-ONLY* Essential Health Benefit</th>
<th>In-Network</th>
<th>Out-of-Network**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class I/Preventive</strong> - Cleanings, Exams, Fluoride, Sealants, Space Maintainers, Emergency Pain, and Radiographs-Bitewings</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Class II/Basic</strong> - Radiographs (Full Mouth X-ray, Panoramic Film) Restorations (Amalgams and Anterior Resins), Simple Extractions and Anesthesia (General Anesthesia and Intravenous Sedation)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Class III/Major</strong> - Surgical Extractions and Endodontics</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Class IV/Orthodontia</strong> Only for pre-authorized Medically Necessary Orthodontia</td>
<td>50% up to OOP for medically necessary orthodontic</td>
<td></td>
</tr>
<tr>
<td>Deductible (waived for Class I) (per person)</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Maximum (OOP) (per person)</td>
<td>$700</td>
<td>N/A</td>
</tr>
<tr>
<td>Out of Pocket Maximum*** (OOP) (per family - 2+ children)</td>
<td>$1,400</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Ortho Lifetime Maximum</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Waiting Period</td>
<td>24 months for medically necessary orthodontics</td>
<td></td>
</tr>
</tbody>
</table>

* This plan is available for individuals up to age 19.
** Benefits are based on the Usual and Customary charges of the majority of dentists in the same geographic area.
***2 family members must each meet the out of pocket maximum in a plan year.

Once fulfilled the family maximum has been met and will not be applied to additional family members.
Benefits and Limitations

This section lists the dental benefits and services you are allowed to obtain through the Plan when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exceptions and limitations listed here and in the Exclusions section of this EOC.

Diagnostic and Preventive Benefits

- Oral Exams
  - Limited to twice in a 12 month period for any combination of oral exams.
- X-Rays
  - Full mouth x-rays complete series (includes bitewings) limited to once in 60 months.
  - Bitewings limited once every 12 months (not a benefit in addition to a complete mouth series)
  - Panoramic films limited to twice in a 12 month period
- Prophylaxis
  - Limited to once in a 12 month period.
- Topical Fluoride Treatment
  - Limited to Twice in a 12 month period.
- Sealants
  - Application only to permanent molar teeth with occlusal surfaces intact, no caries (decay), and/or with no restorations;
  - Does not include prep or conditioning of tooth or any other procedure associated with sealant application;
  - Does not include repair or replacement of sealant on any tooth within 36 months of applications; such repair or replacement done by same dentist considered included in fee for initial placement of sealant.
- Space Maintainer
  - Only for premature loss of deciduous (baby) posterior (back) teeth.
- Palliative Treatment
  - For pain relief.

Basic Restorative Procedures

- Amalgam (metal) Restorations
  - Limited to once in 24 months for the same covered amalgam (metal) restoration.
- Resin (white plastic) Restorations – Anterior (front) Teeth ONLY
  - Limited to once in 24 months for the same covered amalgam (resin) restoration.
- Resin (white plastic) Restorations – Posterior (back) Teeth ONLY
  - Not a benefit unless prior to placement, member is informed and agrees to pay the cost difference between the amalgam (metal) and resign (white plastic) filling feed.

Other Restorative Procedures

- Recement crown; Prefabricated stainless steel crown (primary and permanent teeth); Prefabricated resin crown (anterior tooth only); Prefabricated stainless steel crown with resin window (anterior tooth only)
  - If more than one restoration is used to restore a tooth, benefit allowance will be paid for the most inclusive service;
  - Prefabricated crowns per tooth are a benefit only once in 24 months.

Oral Surgery

- Coronal remnants – deciduous tooth
- Extraction erupted tooth or exposed root (elevation and/pr forceps removal); Surgical removal or erupted tooth requiring elevation of mucoperiosteal flap and removal or bone and/or section of tooth; Removal of impacted tooth (soft tissue/partially bony/completely bony/ completely bony, with unusual surgical complications)
  - Prophylactic removal of 3rd molar is not a covered benefit.

Endodontic

- Therapeutic pulpotomy (primary tooth) excluding final restoration
  - Benefit only for primary (baby) teeth
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- Root canal therapy (anterior/bicuspid/molar) excluding final restoration
  - Benefit for permanent teeth only.

- **Orthodontic Benefits**
- Orthodontic benefits are available when approved prior authorization for medically necessity and have a 24 month waiting period.

**General Exclusions**

Covered Services and Supplies do not include:

1) Treatment which:
   a) is not included in the list of Covered Services and Supplies;
   b) is not Dentally Necessary; or
   c) is Experimental in nature.

2) Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.

3) Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.

4) Replacement of a lost or stolen Appliance or Prosthesis.

5) Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.

6) Completion of claim forms.

7) Missed dental appointments.

8) All services for which a claim is submitted more than 6 months after the date of service.

9) Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.

10) Treatment for a jaw fracture.

11) Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is:
   a) a Close Relative or a person who ordinarily resides with You or a Dependent;
   b) an Employee of the Employer;
   c) the Employer.

12) Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.

13) Services and supplies obtained while outside the United States, except for Emergency Dental Care.

14) Services or supplies resulting from or in the course of Your or Your Dependent's regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers’ Compensation Law, Employer’s Liability Law or similar law. You must promptly claim and notify Us of all such benefits.

15) Any Charges which are:
   a) Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.
   b) Not imposed against the person or for which the person is not liable.
   c) Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify Us that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
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16) Crowns on third molars where adjacent first and second molars are present or where there is no occlusion with opposing.

17) Services and supplies provided primarily for cosmetic purposes.

18) Services and supplies which may not reasonably be expected to successfully correct the Covered Person’s dental condition for a period of at least three years, as determined by Us.

19) Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam resin filling.

20) Orthodontic services, supplies, appliances and Orthodontic-related services for individuals over the age of 19.

21) Pathology free third molar extraction or removal.

22) Crown build-up is not covered as a separate service.

23) Therapeutic drug injection.

24) Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.

25) Temporary tooth stabilization, other than covered space maintainers, is not covered.

26) Oral sedation and nitrous oxide analgesia are not covered, except for Children through age 6.

27) Implants, and procedures and appliances associated with them, are not benefits of Premier programs.

28) Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes.

29) Bridges to replace extracted roots when the majority of the natural crown is missing.

30) Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.

31) Diagnostic casts.

32) Laboratory-processed crowns on over-retained primary teeth.

33) Replacement of stayplates.

34) Replacement of missing teeth prior to coverage effective date.