



# Summary of Benefits

Plan Codes: P102C, P102V or P102W

	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible (waived for preventive)	\$50	\$50
Family Deductible (waived for preventive)	\$150	\$150
Annual Maximum (combined for both In-Network and Out-of-Network)	\$1000	\$1000
Orthodontic Lifetime Maximum (combined for both In-Network and Out-of-Network)	N/A	N/A

COVERED SERVICES	PLAN REIMBURSEMENT		BENEFIT GUIDELINES
	IN-NETWORK	OUT-OF-NETWORK*	
<b>PREVENTIVE &amp; DIAGNOSTIC DENTAL SERVICES</b>			
Periodic Oral Evaluation	100%	100%	Up to 2 per year.
Prophylaxis	100%	100%	Up to 2 per year.
Bitewing X-Rays	100%	100%	Once per 12 months.
Full Mouth X-Rays	100%	100%	Once per 36 months.
Fluoride Treatments	100%	100%	For eligible dependents under age 15, once per 12 months.
Sealants	100%	100%	Once per 36 months.
Space Maintainers	100%	100%	For eligible dependents under age 15, once per lifetime per space.
<b>BASIC DENTAL SERVICES</b>			
Amalgam Fillings	80%	80%	One restoration allowed per surface per 36 months.
Composite Fillings	80%	80%	One restoration allowed per surface per 36 months.
General Anesthesia	80%	80%	Limited to 60 minutes and must be performed at an oral surgeon's office.
Emergency Palliative Care	80%	80%	Will be covered as a separate benefit only if no other services except an exam or x-rays were performed during a visit.
<b>MAJOR DENTAL SERVICES</b>			
Endodontics (Root Canal Treatment)	0%	0%	
Periodontal Maintenance	0%	0%	
Periodontal Scaling and Root Planing	0%	0%	
Periodontal Surgery	0%	0%	
Simple Extractions	0%	0%	
Surgical Extractions of Impacted Tooth	0%	0%	
Crowns	0%	0%	
Bridges	0%	0%	
Dentures	0%	0%	
<b>ORTHODONTIC SERVICES</b>			
Diagnosis and service to correct malalignment of the teeth or bite including Phase I and Phase II.	Not Covered	Not Covered	

\*The out of network reimbursement level is based on the plan's Maximum Allowable Charge (MAC). These limitations are determined by the geographic location in which the expense is incurred. Member is responsible for charges by out-of-network providers that exceed the Maximum Allowable Charge.

This document contains only a summary of your benefits. Please refer to the Certificate of Coverage for a more complete explanation of benefits, including a full listing of exclusions and limitations. In the event of a discrepancy, the Certificate of Coverage will govern.