Summary of Benefits

Plan Codes: P104W

	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**
12 MONTH WAITING PERIOD APPLIES TO MAJOR DENTAL SERVICES	**YES**	**YES**

COVERED SERVICES	PLAN REIMBURSEMENT IN-NETWORK	OUT-OF-NETWORK*	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC DENTAL SERVICES			
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 age 14 and under once per lifetime per space.
BASIC DENTAL SERVICES			
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.
MAJOR DENTAL SERVICES			
Endodontics (Root Canal Treatment)	50%	50%	Once per tooth per lifetime. Re-treatment is limited to once per tooth per lifetime and no sooner than 24 months after initial root canal for same tooth.
Periodontal Maintenance	50%	50%	Limited to 2 per 12 months. Must follow active periodontal treatment.
Periodontal Scaling and Root Planing	50%	50%	Once per quadrant per 36 months.
Periodontal Surgery	50%	50%	Once per quadrant per 36 months.
Simple Extractions	50%	50%	Extractions of wisdom teeth not covered for dependents under age 16.
Surgical Extractions of Impacted Tooth	50%	50%	
Crowns	50%	50%	Limited to once per 7 years.
Bridges	50%	50%	Limited to once per 7 years.
Dentures	50%	50%	Limited to once per 7 years. Not covered for those under age 18.
ORTHODONTIC SERVICES			
Diagnosis and service to correct misalignment 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 are 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.