



Summary of Benefits

Plan Codes: P113C

| | 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) | \$1500 | \$1500 |
| Orthodontic Lifetime Maximum (combined for both In-Network and Out-of-Network) | \$1000 | \$1000 |

| COVERED SERVICES | PLAN REIMBURSEMENT | | BENEFIT GUIDELINES |
|--|--------------------|-----------------|---|
| | IN-NETWORK | OUT-OF-NETWORK* | |
| 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 under age 15, 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. |
| Endodontics (Root Canal Treatment) | 80% | 80% | 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 | 80% | 80% | Limited to 2 per 12 months. Must follow active periodontal treatment. |
| Periodontal Scaling and Root Planing | 80% | 80% | Once per quadrant per 36 months. |
| Periodontal Surgery | 80% | 80% | Once per quadrant per 36 months. |
| Simple Extractions | 80% | 80% | Extractions of wisdom teeth not covered for dependents under age 16. |
| Surgical Extractions of Impacted Tooth | 80% | 80% | |
| MAJOR DENTAL SERVICES | | | |
| 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. | 50% | 50% | Lifetime benefit pro-rated over a 24 month period. For eligible dependents under age 19. |

*The out of network reimbursement level is based on the schedule of Reasonable and Customary charges and is determined by the geographic location in which the expense is incurred. Member is responsible for charges by out-of-network providers that exceed the Reasonable and Customary amount.

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.