



Summary of Benefits

P158

Individual Deductible (waived for preventive)	IN-NETWORK \$50	OUT-OF-NETWORK \$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*	
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 14, once per 12 months.
Sealants	100%	100%	Once per 36 months (age 14 and under).
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 24 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			
N/A	N/A	N/A	N/A

*The 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.