Small Group Dental Plans
(10-50 enrolled employees)

Dental Benefit Summary
100/80/50 $1,000 Max, $1,500 Ortho

Dental Cost-Sharing

	In-Network	Out-of-Network
Annual Individual Deductible - Applies to Type B, C:	$50	$50
Combined Family Maximum - Applies to Type B, C:	$150	$150
Coinsurance - Type A:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Coinsurance - Type B:	Plan Pays 80% / Member Pays 20%	Plan Pays 80% / Member Pays 20%
Coinsurance - Type C:	Plan Pays 50% / Member Pays 50%	Plan Pays 50% / Member Pays 50%
Annual Maximum - Includes Type A,B,C:	$1,000	$1,000
Coinsurance - Type D:	Plan Pays 50% / Member Pays 50%	Plan Pays 50% / Member Pays 50%
Lifetime Maximum - Applies to Type D:	$1,500 per member	$1,500 per member
Annual Maximum Look Back Period:	$250 maximum	$250 maximum

Type A - Preventive and Diagnostic Services

	Limitations	In-Network	Out-of-Network
Prophylaxes	Two (2) scaling, cleaning and polishing treatments per member per contract year.	Type A Coinsurance	Type A Coinsurance
Fluoride Treatments	One (1) fluoride treatments per covered child until age 19 EOY per contract year.	Type A Coinsurance	Type A Coinsurance
Examinations	One (1) routine examination per member per contract year. One (1) initial comprehensive oral evaluation per dentist per member lifetime.	Type A Coinsurance	Type A Coinsurance
X-Rays	Four (4) bitewing x-rays per member per contract year. One (1) full-mouth series of X-rays or one (1) panoramic film once every three (3) years.	Type A Coinsurance	Type A Coinsurance
Space Maintainers	One (1) space maintainer per covered child until age 19 EOY per lifetime.	Type A Coinsurance	Type A Coinsurance
Sealants	One (1) sealant per covered tooth every three (3) contract years per covered child age 6 until age 14 birthdate.	Type A Coinsurance	Type A Coinsurance
Basic Restorations	Fillings, excludes temporary fillings, covered every six (6) months.	Type A Coinsurance	Type A Coinsurance

Type B - Basic Services

	Limitations	In-Network	Out-of-Network
Palliative Services	One (1) emergency service for the relief of pain per member per contract year.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Consultations	Visit will count toward Examinations benefit limit. Specialist visit not covered if performed within one (1) month of consultation.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Extractions	Routine removal of a tooth or teeth.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Repair of Prosthetic Appliances[1, 2]	One (1) denture reline per denture every five (5) years. Rebase or repair of new dentures covered six (6) months from date of insertion. Repair of dentures includes: replacement of broken teeth or clasps, broken facings; recementation of inlays, crowns, bridges, space maintainers; repair of inlays, veneers.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Bedside Calls	Emergency only.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Endodontics (Non-Surgical)	One (1) pulpotomy per tooth per lifetime. Pulp capping is not covered.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Surgical Endodontics (Root Canal Therapy)[2]	Services are covered three (3) months after root canal therapy performed on same tooth by same dentist.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Anesthesia & IV Sedation/Analgesia	Covered in connection with a covered service.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Periodontal Surgery[2]	Five (5) treatments per contract year. Repeated treatments covered three (3) years from date of service. Periodontal appliances are not covered.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance

Periodontal Treatment (Non-Surgical)	Five (5) treatments of diseases of the gums and jaw, including two (2) periodontal maintenance procedure, per member per contract year	Deductible & Type B Coinsurance	Deductible &
Type C - Major Services			**Type B Coinsurance**
	Limitations	**In-Network**	**Out-of-Network**
Oral Surgery[1, 2]	Surgery for removal of erupted tooth, fractured jaws, impactions, and lesions are covered. Corrective jaw surgery and surgery relating to accidental injury is not covered.	Deductible & Type C Coinsurance	Deductible & Type C Coinsurance
Major Restorative Services[2]	Includes: crowns; inlays; prosthetic services; removable, complete and partial dentures; fixed bridges; crowns or inlays used as abutments. Replacements covered after ten (10) years from appliance date of service.	Deductible & Type C Coinsurance	Deductible & Type C Coinsurance
Fixed & Removable Prosthodontics[2]	Includes: permanent dentures, fixed bridgework and removable partial dentures, posts if evidence of root canal therapy on the tooth, pins once every six (6) months. Replacements covered after ten (10) years from date of service. Insertion of fixed bridge and partial denture in same arch covered after ten (10) years from date of service. Adjustment of appliances is covered after one (1) year of insertion.	Deductible & Type C Coinsurance	Deductible & Type C Coinsurance
Implant Services[2]	One (1) surgical implant per tooth per lifetime. Replacements covered after five (5) years from date of service.	Deductible & Type C Coinsurance Maximum $600 Allowance	Deductible & Type C Coinsurance Maximum $600 Allowance
Type D - Orthodontic Services			
	Limitations	**In-Network**	**Out-of-Network**
Orthodontics[2]	Up to twenty (20) months of treatment covered including: office visits, appliances, follow-up visits and retention. Existing appliances are not covered.	Type D Coinsurance	Type D Coinsurance

1 - Subject to Schedule of allowance annual maximum per member per contract year

2 - You may obtain a Predetermination of Benefits, refer to your Certificate of Coverage of additional information

"Annual" means the benefit year in which dental care services are performed.
For those subscribers and their families electing to be serviced by Out-of-Network providers; submitted claims will be processed at any time during the year and reimbursements will be made at the level of coverage listed under "Out-of-Network" and in amounts up to the schedule of allowances paid to participating providers. Payments will be limited to the individual annual maximum listed in the annual maximum section. These benefits may be subject to the plans deductibles and are subject to the plans exclusions and limitations.