

Schedule of Covered Dental Care Services

How Do You Access Benefits?

This Schedule of Covered Dental Care Services: (1) describe the Covered Dental Care Services and any applicable limitations to those services; (2) outline the Co-insurance and any applicable waiting period that you are required to pay for each Covered Dental Care Service; and (3) describe the applicable Deductible and any Maximum Benefits that may apply.

You can choose to receive Network Benefits or out-of-Network Benefits.

Network Dental Providers

We have arranged with certain Dental Providers to participate in a Network. These Network Dental Providers have agreed to discount their charges for Covered Dental Care Services and supplies.

If Network Dental Providers are used, the amount of Covered expenses for which you are responsible will generally be less than the amount owed if out-of-Network Dental Providers had been used. The Co-insurance level remains the same whether or not Network Dental Providers are used. However, because the total charges for Covered expenses may be less when Network Dental Providers are used, the portion that you owe will generally be less.

Directory of Network Dental Providers

A Directory of Network Dental Providers will be made available. You may access the Directory of Network Dental Providers online at www.myuhc.com. You can also call customer service to determine which Dental Providers participate in the Network at [1-800-445-9090].

Network and out-of-Network Benefits

This Schedule of Covered Dental Care Services describes both benefit levels available under the Policy.

Network Benefits

Dental Care Services must be provided by a Network Dental Provider in order to be considered Network Benefits.

The only exception is if you need Emergency care and you are out of your service area or are unable to contact your Network general Dental Provider. In this situation, Emergency care will be covered as a Network Benefit and you will not be responsible for greater out-of-pocket expenses than if you had attended a Network Dental Provider. You must submit appropriate reports and x-rays.

When Dental Care Services are received from an out-of-Network Dental Provider as a result of an Emergency, the Co-insurance will be the Network Co-insurance.

In the case of non-Emergency Orthodontic Services, seek care at the nearest Dental Provider. In this case, the Co-insurance will be the Network Co-insurance unless we can arrange for care by a Network Dental Provider.

Enrolling for Coverage under the Policy does not guarantee Dental Care Services by a particular Network Dental Provider on the list of Dental Providers. The list of Network Dental Providers is subject to change. When a Dental Provider on the list no longer has a contract with us, you must choose among remaining Network Dental Providers. You are responsible for verifying the Network participation status of your Dental Provider, prior to receiving such Dental Care Services.

If you fail to verify whether your treating Dental Provider's participation in the Network, and the failure results in non-compliance with our required procedures, Coverage of Network Benefits may be denied.

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of any applicable deductible, any applicable waiting period and payment of the Co-insurance specified for any service and payment of the percentage of Allowed Amounts shown in this *Schedule of Covered Dental Care Services* and generally require you to pay less to the Dental Provider than out-of-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

Network Benefits:

When Network Co-insurance is charged as a percentage of Allowed Amounts, the amount you pay for Dental Care Services from Network Dental Provider is determined as a percentage of the negotiated contract fee between us and the Dental Provider rather than a percentage of the Dental Provider's billed charge. Our negotiated rate with the Dental Provider is ordinarily lower than the Dental Provider's billed charge.

A Network Dental Provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network Dental Provider may charge you. However, these charges will not be considered Covered Dental Care Services and will not be payable by us.

Out-of-Network Benefits

Out-of-Network Benefits apply when you obtain Dental Care Services from out-of-Network Dental Providers.

Before you are eligible for Coverage of Dental Care Services obtained from out-of-Network Dental Providers, you must meet the requirements for payment of the applicable deductible and appropriate waiting period stated below. Generally you are required to pay more than Network Benefits. Out-of-Network Dental Providers may request that you pay all charges when services are rendered. You must file a claim with us for reimbursement of Allowed Amounts.

We will reimburse an Out-of-Network Dental Provider for a Covered Dental Care Service up to an amount equal to the Contracted Fee for the same Covered Dental Care Service received from a similarly situated Network Dental Provider. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Care Service may exceed the Contracted fee. As a result, you may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Care Service in excess of the Contracted fee. In addition, when you obtain Covered Dental Care Services from an out-of-Network Dental Provider, you must file a claim with us to be reimbursed for Allowed Amounts.

Classes of Dental Benefits

Listed below are the class categories of Covered Dental Care Services. The table below will provide information on your specific benefits and class of the dental care service.

Class I – Dental Benefits:

- Diagnostic Services
- Preventive Services
- Radiographs
- Space Maintainers
- Sealants

Class II – Dental Benefits:

- Adjunctive Services
- Endodontic Services
- Minor Restorative Services
- Oral Surgery Services
- Periodontic Services
- Emergency Palliative Treatment

Class III – Dental Benefits:

- Major Restorative Services
- Prosthodontic Services
- Removable Dentures
- Cosmetic

BENEFIT DESCRIPTION & LIMITATION	NATIONAL PPO NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
CLASS I DIAGNOSTIC SERVICES ORAL EVALUATION (DIAGNOSTIC) X-RAYS – OTHER X-RAYS – BITEWINGS X- RAYS-INTRAORAL/EXTRAORAL PROPHYLAXIS (PREVENTIVE) FLUORIDE TREATMENT PREVENTIVE SEALANTS EXCEPT CONE BEAMS		
Bacteriologic Cultures	0%	0%
Viral Cultures	0%	0%
Intraoral Bitewing Radiographs Images	0%	0%

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Limited to 1series of images per calendar year		
Panorex Radiographs Image Limited to 1 time per consecutive -36 months	0%	0%
Oral/Facial Photographic Images Limited to 1- time per consecutive 36 months	0%	0%
Cone Beam CT Capture and Interpretation with Limited Field of View – Less than One Whole Jaw Limited to 1 time every consecutive 60 months	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Mandible Limited to 1 time every consecutive 60 months	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Maxilla, With and Without Cranium Limited to 1 time every consecutive 60 months	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Cone Beam CT Capture and Interpretation with Field of View of Both Jaws, With and Without Cranium Limited to 1 time every consecutive 60 months	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Diagnostic Casts	0%	0%

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Limited to 1 time per consecutive 24 months		
Extraoral Radiographs Images Limited to 2 images per calendar year	0%	0%
Intraoral - Complete Series of Radiograph Images Limited to 1 time per consecutive 36 months Vertical bitewings cannot be billed in conjunction with a complete series.	0%	0%
Intraoral Periapical Radiographs Image Limited to 8 images per calendar year	0%	0%
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	0%	0%
Intraoral Occlusal Radiographs Image Limited to 2 images per consecutive 6 months	0%	0%
Vertical Bitewings, 7-8 Radiograph Images Limited to 1 series of images per consecutive 36 months Vertical bitewings cannot be billed in conjunction with a complete series.	0%	0%
Periodic Oral Evaluation .	0%	0%

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Limited to 2 times per consecutive 12 months		
Comprehensive Oral Evaluation Limited to new patients or 2times per consecutive 12 months for established patients. Not covered if done in conjunction with other exams.	0%	0%
Limited or Detailed Oral Evaluation Limited to 2times per consecutive 12 months. Only 1 exam is covered per date of service.	0%	0%
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per consecutive 12 months	0%	0%
Oral Evaluation for a Patient under three Years of Age and Counseling Primary Caregiver Limited to 2 times per consecutive 12 months Not covered if done in conjunction with other exams.	0%	0%
Teledentistry – synchronous; real-time encounter Limited to 2 times per consecutive 12 months].	0%	0%

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Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review Limited to 2timesper consecutive 12 months	0%	0%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1time per consecutive 12 months	0%	0%
CLASS I PREVENTIVE SERVICES		
Dental Prophylaxis Limited to 2 times per consecutive 12 months	0%	0%
Fluoride Treatments - child Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months	0%	0%
Sealants Limited to Covered Persons under the age of 16years and once per first or second permanent molar every consecutive 36 months	0%	0%
Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	0%	0%

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Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months		
CLASS I SPACE MAINTAINERS		
Space Maintainers Limited to Covered Persons under the age of -16 years, once per consecutive 60 months]. Benefit includes all adjustment within 6 months of installation.	0%	0%
Re-Cementation of Space Maintainers Limited to 1 per consecutive 6 months after initial insertion.	0%	0%
Removal of Fixed Space Maintainer	0%	0%
CLASS II MINOR RESTORATIVE SERVICES		
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Gold Foil Restorations	40%	40%

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Multiple restorations on one surface will be treated as a single filling	Subject to a 3 month Waiting Period	Subject to a 3 month Waiting Period
CLASS II ENDODONTICS		
Apexification Limited to 1 time per tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Apicoectomy Limited to 1 time per tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Retrograde Filling Limited to 1 time per tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Hemisection Limited to 1 time per tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist cannot charge retreatment codes on tooth treated for the first 12 months.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Root Resection/Amputation	40%	40%

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Limited to 1time per tooth per lifetime.	Subject to a 3 month Waiting Period	Subject to a 3 month Waiting Period
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 per tooth per lifetime. Covered for anterior or posterior teeth only.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Pulp Caps - Direct/Indirect – excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Pulpal Debridement, Primary and Permanent Teeth Not covered if done by same dentist performing definitive root canal therapy. Limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Pulpal Regeneration - (Completion of Regenerative Treatment in an Immature Permanent Tooth with a Necrotic Pulp) does not include Final Restoration	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period

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Limited to 1 per tooth per lifetime		
CLASS II PERIODONTICS		
Crown Lengthening Limited 1 per quadrant or site per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Gingivectomy/Gingivoplasty Limited 1 per quadrant or site per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Gingival Flap Procedure Limited 1 per quadrant or site per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Osseous Graft Limited 1 per quadrant or site per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Osseous Surgery Limited 1 per quadrant or site per consecutive -36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Guided Tissue Regeneration Limited 1 per quadrant or site per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period

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Soft Tissue Surgery Limited 1 per quadrant or site per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Surgical Revision Procedure Limited 1 per quadrant or site per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Periodontal Maintenance Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Full Mouth Debridement Limited to once per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period

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Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant or 12 sites total per lifetime for refractory pockets or in conjunction with Periodontal Scaling and Root Planing	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
CLASS II ORAL SURGERY		
Alveoloplasty	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Biopsy Limited to 1 biopsy per site per visit.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Frenectomy/Frenuloplasty	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Surgical Incision Limited to 1 per site per visit.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Removal of a Benign Cyst/Lesions	40%	40%

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Limited to 1 per site per visit.	Subject to a 3 month Waiting Period	Subject to a 3 month Waiting Period
Removal of Torus Limited to 1 per site per visit.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Root Removal, Surgical Limited to 1 per site per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Simple Extractions Limited to 1 per site per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Surgical Extraction of Erupted Teeth or Roots Limited to 1 per site per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Surgical Extraction of Impacted Teeth Limited to 1 per site per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to 1 per tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period

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Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Vestibuloplasty Limited to 1 time per site per consecutive 60 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Bone Replacement Graft for Ridge Preservation - per site Limited to 1 per site per lifetime. Not covered if done in conjunction with other bone graft replacement procedures.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 per site per consecutive 36 months	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar Limited to once per appliance per lifetime.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period

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<p>Tooth Reimplantation and/or Transplantation Services</p> <p>Limited to 1 per site per lifetime.</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>
<p>Oroantral Fistula Closure</p> <p>Limited to 1 per site per visit.</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>
CLASS II ADJUNCTIVE SERVICES		
<p>Analgesia</p> <p>Covered when Necessary in conjunction with Covered Dental Care Services.</p> <p>If required for patients under 7 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>
<p>Desensitizing Medicament</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>
<p>General Anesthesia</p> <p>Covered when Necessary in conjunction with Covered Dental Care Services.</p> <p>If required for patients under 7 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 7 if it is clinically Necessary.</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>	<p>40%</p> <p>Subject to a 3 month Waiting Period</p>

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Local Anesthesia Not covered in conjunction with operative or surgical procedure.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to 1 per visit	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Occlusal Adjustment	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Occlusal Guards Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period

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insertion. Limited to 1 time per consecutive 12 months		
Occlusion Analysis - Mounted Case Limited to [1-2] [time] per consecutive [24-60 months]	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Emergency Palliative Treatment Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not covered if done with exams or professional visit.	40% Subject to a 3 month Waiting Period	40% Subject to a 3 month Waiting Period
CLASS III MAJOR RESTORATIVE SERVICES Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive [60-120 months] from initial or supplemental placement.		
Coping Limited to 1 per tooth per consecutive 60 months Not Covered if done at the same time as a crown on same tooth.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Crowns – Retainers/Abutments	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

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Limited to 1 time per tooth per consecutive 60 months Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.		
Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Temporary Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Inlays/Onlays – Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

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Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.		
Pontics Limited to 1 time per tooth per consecutive 60 months	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to [1-2] [time] per consecutive [60-120 months].	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period]
Pin Retention Limited to 2 pins per tooth; not covered in addition to cast restoration.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Post and Cores Covered only for teeth that have had root canal therapy.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to those performed more than 12 months after the initial insertion.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Protective Restoration Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

BENEFIT DESCRIPTION & LIMITATION	NATIONAL PPO NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
CLASS III FIXED PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive [60-120 months] from initial or supplemental placement.		
Fixed Partial Dentures (bridges) Limited to 1 time per tooth per consecutive [60	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
CLASS III REMOVABLE PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive [60-120 months] from initial or supplemental placement.		
Full Dentures Limited to 1 per consecutive 60 months No additional allowances for precision or semi-precision attachments.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Partial Dentures Limited to 1 per consecutive 60 months No additional allowances for precision or semi precision attachments.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

BENEFIT DESCRIPTION & LIMITATION	NATIONAL PPO NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 24 months	50% [Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
CLASS III COSMETIC		
Labial Veneer (lamine) – Chairside Limited to 1 time per tooth per consecutive 60 months Covered only when a filling cannot restore the tooth.	50% Subject to a [–12month Waiting Period	50% Subject to a 12 month Waiting Period.
Labial Veneer (resin lamine) - Laboratory Limited to 1 time per tooth per consecutive 60 months Covered only when a filling cannot restore the tooth.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

BENEFIT DESCRIPTION & LIMITATION	NATIONAL PPO NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Labial Veneer (porcelain laminate) - Laboratory Limited to 1 time per tooth per consecutive 60 months Covered only when a filling cannot restore the tooth.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

Covered Dental Care Services are subject to satisfaction of any applicable Waiting Periods, applicable Deductibles, Maximum Benefits and payment of any Co-insurance as stated below.

Cost Share: Deductibles and Benefit Maximums

Deductible

Annual Deductible is \$25 per Covered Person for Network Benefits and \$25 per Covered Person for out-of-Network Benefits per Calendar Year

The Annual Deductible will not exceed \$75 for Network Benefits and \$75 for out-of-Network Benefits for all Covered Persons in a family per Calendar Year

The Annual Deductible applies to: ALL COVERED DENTAL CARE SERVICES

Maximum Benefit is \$500 per Covered Person for Network Benefits and \$500 per Covered Person for out-of-Network Benefits per Calendar Year

The Maximum Benefit applies to: ALL COVERED DENTAL CARE SERVICES

All Dental Care Services and procedures follow the criteria specified in the Current Dental Terminology (CDT) listing as defined by the American Dental Association.