

**Dental Options PPO  
Covered Dental Services (Custom-No Orthodontics)**

**“Low Option” - P3813**

|   | In-Network                                  | Out-of-Network                              |
|---|---|---|
| <b>Individual Annual Deductible</b>                                       | <b>\$50</b>                                 | <b>\$100</b>                                |
| <b>Family Annual Deductible</b>   | <b>\$150</b>                                | <b>\$300</b>                                |
| <b>Maximum (combined for both In-Network and Out-of-Network services)</b> | <b>\$ 1000 per person per calendar year</b> | <b>\$ 1000 per person per calendar year</b> |

|  | In-Network | Out-Of-Network |
|--|------------|----------------|
| <b>Annual deductible applies to preventive and diagnostic services</b> | <b>No</b>  | <b>No</b>      |
| <b>This plan has no waiting periods.</b>                               |            |                |

| Covered Services                                 | In-Network Plan Pays* | Out-of-Network Plan Pays** | Benefit Guidelines   |
|--|-----------------------|----------------------------|--|
| <b>Preventive and Diagnostic Dental Services</b> |                       |                            |  |
| Periodic Oral Examinations                       | 100%                  | 10%                        | Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to once every 6 months.                              |
| Bitewing X-rays                                  | 100%                  | 10%                        | Limited to 1 series of films per calendar year.  |
| Complete Series or Panorex X-rays                | 100%                  | 10%                        | Limited to one time per 36 months.   |
| Dental Prophylaxis (Cleanings)                   | 100%                  | 10%                        | Limited to once every 6 months.  |
| Fluoride Treatments                              | 100%                  | 10%                        | Limited to Covered Persons under the age of 16 years, and limited to once per six month period. Treatment should be done in conjunction with dental prophylaxis. |
| Sealants   | 100%                  | 10%                        | Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every 3 years.   |
| <b>Basic Dental Services</b>                     |                       |                            |  |
| Amalgam Restorations                             | 100%                  | 10%                        | Multiple restorations on one surface will be treated as a single filling.  |
| Composite Resin Restorations (Fillings)          | 100%                  | 10%                        | Multiple restorations on one surface will be treated as a single filling.  |
| Space Maintainers                                | 100%                  | 10%                        | Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.                        |
| Simple Extraction                                | 100%                  | 10%                        |  |
| General Anesthesia                               | 100%                  | 10%                        | When clinically necessary  |