

Enhanced Dental PPO Pediatric 60/0*

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	Participating Dentists	Non-Participating Dentists ⁵
Calendar Year Deductible ¹	\$60 per member / \$120 per family (applies to all covered services; all providers combined)	
Calendar Year Benefit Maximum	No maximum	\$1,000 per member
Calendar Year Out-of-Pocket Maximum ^{1,2}	\$1,000 per member / \$2,000 per family	No maximum

Covered Services	Member Copayments	
	Participating Dentists	Non-Participating Dentists ⁵
Diagnostic and Preventive Care Services		
Prophylaxis services (cleanings), X-rays, initial and periodic oral examinations, consultations, topical fluoride treatment, preventive dental education and oral hygiene instruction, space maintainers, and dental sealant treatments	No charge	20%
Restorative Services		
Fillings (amalgam, composite resin, acrylic, synthetic or plastic), sedative base and sedative fillings, non-cosmetic micro-filled resin restorations, replacement of a restoration, use of pins and pin build-up in conjunction with a restoration	50%	50%
Oral surgery³		
Extractions (including surgical), removal of impacted teeth, biopsy of oral tissues, alveolectomies, excision of cysts and neoplasms, treatment of palatal torus, treatment of mandibular torus, frenectomy, incision and drainage of abscesses, post-operative services (including exams), suture removal and treatment of complications, root recovery	50%	50%
Endodontics³		
Direct pulp capping, pulpotomy and vital pulpotomy, apexification filling with calcium hydroxide, root amputation, root canal therapy (including culture canal), retreatment of previous root canal therapy, apicoectomy and vitality tests	50%	50%
Periodontics³		
Emergency treatment (including treatment for periodontal abscess and acute periodontitis, periodontal scaling, and root planning), subgingival curettage, gingivectomy and osseous or mucogingival surgery	50%	50%

Covered Services	Member Copayments	
	Participating Dentists	Non-Participating Dentists
Orthodontics ^{3,4} (medically necessary)	50%	50%
Other Benefits		
Local anesthetics, general anesthesia, emergency treatment, palliative treatment	No charge	20%

Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

1. For families with two (2) or more children enrolled in this pediatric dental plan, the calendar year out-of-pocket maximum is limited to \$2,000 for all children enrolled (\$1,000 per child, times a maximum of two children).
2. The calendar year deductible and copayments for covered services from participating dentists accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services received from participating dentists. Costs for non-covered services, services from non-participating dentists, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.
3. There are no waiting periods for major and orthodontic services.
4. Medically necessary orthodontia services include an oral evaluation and diagnostic casts. An initial orthodontic examination (a Limited Oral Evaluation) must be conducted which includes completion of the Handicapping Labio-Lingual Deviation (HLD) Score sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the member qualifies for medically necessary orthodontic services. Diagnostic casts may be covered only if qualifying conditions are present. Pre-certification for all orthodontia evaluation and services is required.

This plan is pending regulatory approval.