Preferred Dental PPO Pediatric 50/0*

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]	$50 per member / $100 per family (applies to all covered services except diagnostic and preventive care)	$50 per member / $100 per family (applies to all covered services except diagnostic and preventive care and orthodontics)
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	20%	30%
Oral Surgery[3]		
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%
Endodontics[3]		
Direct pulp capping, pulpotomy and vital pulpotomy, apexification filling with calcium hyrdoxide, root amputation, root canal therapy (including culture canal), retreatment of previous root canal therapy, apicoectomy and vitality tests	50%	50%

Covered Services	Member Copayments	
	Participating Dentists	Non-Participating Dentists[5]
Periodontics[3]		
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%
Crowns and Fixed Bridges[3]		
Crowns (acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold only, three-quarter crown, stainless steel), related dowel pins and pin build-up, fixed bridges (which are cast porcelain baked with metal, or plastic processed to gold), recementation of crowns, bridges, inlays and onlays, cast post and core (including cast retention under crowns), repair or replacement of crowns, abutments or pontics	50%	50%
Removable Prosthetics[3]		
Dentures (full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers), office or laboratory relines, denture repair and denture adjustment	50%	50%
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.

* Pending regulatory approval.

1. For families with two (2) or more children enrolled in this pediatric dental plan:
   a. The calendar year deductible is limited to $120 for all children enrolled ($60 per child, deductible not to exceed $120); and,
   b. The calendar year out-of-pocket maximum is limited to $2,000 for all children enrolled ($1,000 per child, maximum not to exceed $2,000).
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.
5. For covered services rendered by non-participating dentists, the member is responsible for all charges above the allowable amount.

This plan is pending regulatory approval.

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