# PPO Low Dental Plan / Covered dental services

| | Non-orthodontics | | Orthodontics | |
|---|---|---|---|---|
| | Network | Non-network | Network | Non-network |
| Individual annual deductible | $50 | $50 | N/A | N/A |
| Family annual deductible | $150 | $150 | N/A | N/A |
| Maximum (the sum of all network and non-network benefits will not exceed annual maximum) | $1,500 per person per calendar year | $1,500 per person per calendar year | Not Covered | Not Covered |
| New enrollees' waiting period | None | | | |
| Annual deductible applies to preventive and diagnostic services | No | | | |
| Annual deductible applies to orthodontic services | N/A | | | |
| Orthodontic eligibility requirement | Not Covered | | | |

| Covered services | Network plan pays | Non-network plan pays | Benefit guidelines |
|---|---|---|---|
| **Diagnostic services** | | | |
| Periodic oral evaluation | 100% | 100% | See exclusions and limitations section for benefit guidelines |
| Lab and other diagnostic tests | 100% | 100% | |
| Radiographs | 80% | 80% | |
| **Preventive services** | | | |
| Prophylaxis (cleaning) | 100% | 100% | See exclusions and limitations section for benefit guidelines |
| Fluoride treatment (preventive) | 100% | 100% | |
| Sealants | 100% | 100% | |
| Space maintainers | 100% | 100% | |
| **Basic services** | | | |
| Restorations, amalgams or composite (anterior and posterior) | 80% | 80% | See exclusions and limitations section for benefit guidelines |
| Emergency treatment/general services | 80% | 80% | |
| Simple extractions | 80% | 80% | |
| Oral surgery (incl. surgical extractions) | 50% | 50% | |
| Periodontics | 50% | 50% | |
| Endodontics | 50% | 50% | |

continued

| Covered services | Network plan pays | Non-network plan pays | Benefit guidelines |
|---|---|---|---|
| **Major services** | | | |
| Inlays/onlays/crowns | 50% | 50% | See exclusions and limitations section for benefit guidelines |
| Dentures and removable prosthetics | 50% | 50% | |
| Fixed partial dentures (bridges) | 50% | 50% | |
| Implants | 50% | 50% | |
| **Orthodontic services** | | | |
| Orthodontia | Not Covered | Not Covered | |

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for veneers, please refer to your certificate of coverage.

Cone beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for cone beams, please refer to your certificate of coverage.

In accordance with the Illinois state requirement, a partner in a civil union is included in the definition of dependent. For a complete description of dependent coverage, please refer to your certificate of coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your certificate of coverage or contact your benefits administrator. If differences exist between this summary of benefits and your certificate of coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

## Have more questions?

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