



## 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
<b>Diagnostic services</b>			
Periodic oral evaluation	100%	100%	See exclusions and limitations section for benefit guidelines
Lab and other diagnostic tests	100%	100%	
Radiographs	80%	80%	
<b>Preventive services</b>			
Prophylaxis (cleaning)	100%	100%	See exclusions and limitations section for benefit guidelines
Fluoride treatment (preventive)	100%	100%	
Sealants	100%	100%	
Space maintainers	100%	100%	
<b>Basic services</b>			
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%	

Covered services	Network plan pays	Non-network plan pays	Benefit guidelines
<b>Major services</b>			
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%	
<b>Orthodontic services</b>			
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.

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