SUMMARY OF COVERAGE	BASIC PLUS			ENHANCED		
	PPO™	Premier®	Out-of-Network	PPO™	Premier®	Out-of-Network
Deductible						
Individual	$50*	$50*	$50*	$50*	$50*	$50*
Family	$150*	$150*	$150*	$150*	$150*	$150*
Benefit Period Maximum per person per calendar year	$1,000			$2,000		
BENEFIT CATEGORIES	Coinsurance paid by member					
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays)	0%	0%	0%	0%	0%	0%
Routine & Restorative Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	30%	30%	30%	20%	20%	20%
Posterior Composites (tooth-colored filling on back teeth)	30%	30%	30%	20%	20%	20%
Endodontic Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)	30%	30%	30%	20%	20%	20%
Periodontal Services (gum and bone diseases, complex procedures)	30%	30%	30%	20%	20%	20%
Temporomandibular Joint Dysfunction (TMD)**	50%	50%	50%	50%	50%	50%
High Cost Restorations (cast restorations – crowns, inlays, onlays, posts, cores)	50%	50%	50%	50%	50%	50%
Prosthetics (bridges, dentures)	50%	50%	50%	50%	50%	50%
Implants	50%	50%	50%	50%	50%	50%
Corrective Orthodontia Benefit & Lifetime Maximum up to age 26	Not Covered			50% coinsurance and $1,500 lifetime maximum (includes adults)		
Enhanced Benefits***	Not Included			Included		

Eligible children up to age 26.
*Deductible is waived for all diagnostic and preventive care.
**Temporomandibular Joint Dysfunction (TMD) eligible covered services may include diagnostic x-rays or surgery in connection with TMD.
***The Enhanced Benefits Program (EBP) allows additional benefits for Covered Person(s) with designated dental or medical conditions. Please refer to your dental benefits document for details.

The information on this page summarizes your benefits and payment obligations. This is a general description of your benefits. Please see your benefits document for a full description of coverage.

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