

Benefit Summary Plan 20

Dental



Calendar Year Deductible	\$50/member; maximum of \$150 family <ul style="list-style-type: none">• Applies to Basic and Major Services• Maximum of three deductibles per family• No Deductible on Preventive Services
Annual Maximum	\$1,500
Coinsurance Amounts	100% Preventive Services 80% Basic Services 50% Major Services
Predetermination of Benefits	Required for charges in excess of \$350
Additional Information	<ul style="list-style-type: none">• If this dental plan is not replacing another dental plan, major services will not be covered for the first 12 months.• For any late entrants to the program, basic services will not be covered for the first 12 months and major services will not be covered for the first 18 months.
See Certificate Booklet for Complete Details:	It is important to keep in mind that this material is a brief outline of benefits and covered service and is not a contract. Please refer to your Certificate Booklet (the Contract) for a complete explanation of covered services, limitations and exclusions.

Dental Coinsurance Covered Procedures

100% Preventive Services

- Routine oral examinations
- Prophylaxis (two per year)
- Topical applications of fluoride
- Space maintainers
- Diagnostic casts
- Pulp vitality testing (one per year)
- Dental X-rays

80% Basic Services

- Fillings
- Oral surgery
- Simple extractions
- Periodontic services
- Other visits and exams
- Repair of removable dentures
- Re-cement crowns and bridges
- Palliative emergency treatment
- Occlusal guards (one per year)

50% Major Services

- Inlays
- Crowns
- Bridges
- Dentures
- Denture rebase or relines
- Repair of fixed bridge
- Endodontics

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