

Part III: MAXIMUMS POLICY WILL PAY

Maximums	All Providers
Annual Maximum	\$2,000
Lifetime or Annual Maximum for Orthodontia	None

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package has no waiting periods.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	All Providers	Benefit Limitations and Exclusions
<i>Oral Exam</i>	Preventive & Diagnostic	0% Deductible does not apply	<ul style="list-style-type: none"> • 3 per calendar year • Refer to Certificate of Coverage document for the full limitation and exclusion
<i>Bitewing X-ray</i>	Preventive & Diagnostic	0% Deductible does not apply	<ul style="list-style-type: none"> • 2 per calendar year, to age 18 • 1 per calendar year, age 18+ • Refer to the Certificate of Coverage document for the full limitation and exclusion
<i>Cleaning</i>	Preventive & Diagnostic	0% Deductible does not apply	<ul style="list-style-type: none"> • 3 per calendar year • Refer to the Certificate of Coverage document for the full limitation and exclusion
<i>Filling</i>	Basic	20%	<ul style="list-style-type: none"> • Refer to the Certificate of Coverage document for the full limitation and exclusion
<i>Extraction, Erupted Tooth or Exposed Root</i>	Major	50%	<ul style="list-style-type: none"> • Refer to the Certificate of Coverage document for the full limitation and exclusion
<i>Root Canal</i>	Major	50%	<ul style="list-style-type: none"> • Refer to the Certificate of Coverage document for the full limitation and exclusion
<i>Scaling and Root Planing</i>	Major	50%	<ul style="list-style-type: none"> • Periodontic services include a 9-month waiting period • Refer to the Certificate of Coverage document for the full limitation and exclusion
<i>Ceramic Crown</i>	Major	50%	<ul style="list-style-type: none"> • Replacement of Crowns, Jackets, Inlays and onlays shall be provided only once in any five-year period and then only in the event that the existing Crown, Jacket, Inlay or onlay is not satisfactory and cannot be made satisfactory • Refer to the Certificate of Coverage document for the full limitation and exclusion
<i>Removable Partial Denture</i>	Major	50%	<ul style="list-style-type: none"> • Prosthodontic appliances will be replaced only after five years have elapsed • Refer to the Certificate of Coverage document for the full limitation and exclusion

Common Dental Procedures	Category	All Providers	Benefit Limitations and Exclusions
<i>Extraction, Erupted Tooth with Bone Removal</i>	Major	50%	<ul style="list-style-type: none"> Refer to the Certificate of Coverage document for the full limitation and exclusion
<i>Orthodontia</i>	Orthodontia	Not Covered	

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

	Example 1	Example 2	Example 3
Activity	Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
Procedure	New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate
Total Cost	In-network: \$400 Out-of-network: \$550	In-network: \$150 Out-of-network: \$200	In-network: \$1,300 Out-of-network: \$1,750
Deductible	In-network: \$0 Out-of-network: \$0	In-network: \$40 Out-of-network: \$40	In-network: \$40 Out-of-network: \$40
Annual Maximum (Plan Will Pay)	In-network: \$2,000 Out-of-network: \$2,000	In-network: \$2,000 Out-of-network: \$2,000	In-network: \$2,000 Out-of-network: \$2,000
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 0%	In-network: 20% Out-of-network: 20%	In-network: 50% Out-of-network: 50%

Part VI: COVERAGE EXAMPLES, cont.

<p>Patient would pay (includes copays/coinsurance and deductible, if applicable):</p>	<p>Dana would pay (includes copays/coinsurance and deductible, if applicable):</p> <p>In-network: \$0</p> <p>Out-of-network: \$0</p>	<p>Sam would pay (includes copays/coinsurance and deductible, if applicable): In-network: \$62</p> <p>Out-of-network: \$72</p>	<p>Maria would pay (includes copays/coinsurance and deductible, if applicable): In-network: \$670</p> <p>Out-of-network: \$895</p>
<p>Summary of what is not covered or subject to a limitation</p>	<p>Oral examinations allowed three times per calendar year.</p> <p>FMX limited to once per 60 months.</p> <p>Cleanings allowed three times per calendar year</p>		