Calendar Year Deductible

Procedure Type	In-Network Deductible	Out-of-Network Deductible
Type I Preventive Services	Not applicable	
Type II Basic Services	$50 individual / $150 family	$50 individual / $150 family
Type III Major Services		
Type IV Ortho Services	Not applicable	

Deductible values are combined between In-Network and Out-of-Network.

Coinsurance

	In-Network	Out-of-Network
Type I Preventive Services	100%	100%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%

Benefit Waiting Periods

- A Late Entrant Benefit Waiting Period of 6 months for Type II Basic Restorations, 12 months for all other Type II Basic Services, and 12 months for Type III Major Services will apply to employees who enroll in this dental plan more than 31 days after becoming eligible.

Calendar Year Maximum Benefit

	In-Network	Out-of-Network
Types I, II and III (Preventive, Basic and Major) Services	$750 per person	$750 per person

Type I Preventive covered dental expenses	Coverage limitations
Oral Evaluations	2 in any 12 consecutive months
Dental Prophylaxis (Cleanings)	2 per 12 months - frequency combined with Periodontal Maintenance and is limited to 4 in any 12 month consecutive period
Fluoride Treatments	Covered Persons under age 14 1 in any 6 consecutive months
Sealants	Covered Persons under age 14 Once per tooth per 36 consecutive months on permanent first and second molars
Bite-Wing X-Rays	1 in 12 consecutive months
Type II Basic covered dental expenses	**Coverage limitations**
Full Mouth X-Rays	1 in 60 consecutive months
Palliative Treatment	Paid as a separate benefit only if no treatment, except x-rays, was rendered during the visit
Amalgam Restorations	Once per tooth surface in any 24 consecutive months
Composite and Silicate Restorations	Once per tooth surface in any 24 consecutive months (Anterior and Posterior teeth)
Space Maintainers	Covered Persons under age 19 Once per tooth in any 3 year period
Type III Major covered dental expenses	**Coverage limitations**
Inlays and Onlays	Covered if tooth cannot be restored by fillings Once per tooth in any 10 years period
Crowns	Covered if tooth cannot be restored by filling or other means Once per tooth in any 10 years period
Crown Buildup	Once per 10 years
Full or Partial Dentures	Once in any 10 years
Fixed Bridges	Once in any 10 years
Periodontal Maintenance	Periodontal Maintenance following active Periodontal Therapy - 1 time in 3 consecutive months. The number of Dental Prophylaxis and Periodontal Maintenance is combined and is limited to 4 in any 12 consecutive month period.
Periodontics (Non-Surgical): Scaling and Root Planing	Once per 36 consecutive months per area of the mouth
Surgical Periodontics	Once per 36 consecutive months per area of the mouth
Endodontics: Root Canal Therapy	Root Canal Therapy is limited to 1 time per tooth in any consecutive 24 months period
Oral Surgery: Surgical Extraction of Erupted and Impacted Teeth	Multiple surgical services on 1 area of the mouth will be based on the most inclusive procedure
General Anesthesia	Benefits payable as a separate expense only when required for the surgical extraction of an impacted tooth
Surgical Implants	Once per 10 years