



	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	\$25 Individual/\$75 Family Applies to: • Basic Care • Major Care	\$25 Individual/\$75 Family Applies to: • Preventive Care • Basic Care • Major Care
Preventive Care • Routine cleanings • Check-ups • X-rays • Fluoride treatments • Routine cleanings, check-ups and bitewing x-rays covered twice per year	100%, no deductible NOTE: No charge for topical fluoride application – up to age 16.	
Basic Care • Fillings • Extractions • Endodontics • Periodontics	85% after deductible	70% after deductible
Major Care • Crowns • Bridges • Dentures	60% after deductible	50% after deductible
Orthodontic Care Available to children up to age 19	50%, no deductible 12-month waiting period	
Maximums • Dental Care (Calendar Year) • Orthodontia (Dependent Children)	• \$2,000 per person • No maximum	

Dental Customer Service: 888-381-9727

This benefit summary does not contain a complete list of benefits available to you nor does it contain a listing of exclusions, limitations and conditions which apply to the benefits shown. Full information can be found only in the Group Contract and Certificate of Benefits.

Out of Network - Members may be balanced billed by the provider for charges over the allowable amount.