

Not available in the following states*:

Alaska, Massachusetts, Montana, New Mexico, Nevada, South Dakota, Virginia, Wyoming

	In Network	Out of Network (fee schedule)	Waiting Period
Benefit Year Maximum (Yr. 1/2/3)	\$500/\$750/\$1,000		
Deductible	\$50 (Waived for Preventive)	\$50 (Not waived for Preventive with the exception: MS, GA, TX)	
Preventative / Diagnostic	80%	80% (Fee schedule, except in: CT, IA, MO, NC, ND, NH, SC, and VT where OON is based on UCR.)	None
Office Visits	Oral evaluations; 1 in a 6-month period. Comprehensive evaluation: 1 in 36-month period		
Teledentistry Evaluation	1 in a 6-month period We pay up to \$50 per covered services		
Emergency Treatment	After-hours office visit or emergency palliative treatment: Limited to 1 in a 6-month period. Covered when no other treatment, other than radiographs, is performed in the same visit.		
Routine cleaning	1 cleaning in 6 consecutive months.		
Routine X-rays	Bitewings-limited to a max of 4 radiographic images or a set of vertical bitewings. 1 in 12 consecutive months. Panoramic radiographic image-limited to 1 in 60 consecutive months.		
Basic Restorative Services	50%	50% (Fee schedule, except in: CT, IA, MO, NC, ND, NH, SC, and VT where OON is based on UCR.)	None
Diagnostic	Diagnostic consultation with a Dentist other than the one providing treatment: Limited to 1 per dental specialty in a 12-month period. Covered when no other treatment, other than radiographs, is performed during the visit.		
Non-surgical extractions	Extraction erupted tooth or exposed root: Allowance includes the treatment plan, local anaesthetic, and post-treatment care.		
Prefabricated stainless steel crown	1 per tooth in a 24-month period		

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Alaska,

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Major Services	50%	50% (Fee schedule, except in: CT, IA, MO, NC, ND, NH, SC, and VT where OON is based on UCR.)	12 months ME-no waiting period for Paediatric Services WA. -none VT. – 6 months
Dental Implants	Lifetime maximum for implants \$700 Replacement: 10 years. Limited to the replacement of permanent teeth. Dental prosthesis replacement limitation and missing tooth provision apply.		
Crown/Inlays/Onlays	Limited to permanent teeth. Covered when needed because of decay or Injury and only when the tooth cannot be restored with amalgam or resin based composite filling material. Replacement: 10 years and unusable		
Bridges	1 in 10 years		
Dentures	Replacement: 10 years and unusable /Upper or lower arch		
Oral Surgery	Allowance includes the treatment plan, local anaesthetic, and post-surgical care. Surgical removal of erupted teeth, removal of impacted teeth, surgical removal of residual tooth roots.		
Endodontics	Limited to permanent teeth and one pulp cap per tooth, per lifetime; Considered when no other endo procedure has been performed on the same tooth.		
Periodontic Services	Limited to one periodontal maintenance or prophylaxis in a 6-month period. Periodontal scaling and root planning limited to once per quadrant in a 24-month period.		
Orthodontia Services (age limit 19)	Not Included		
Teeth Whitening Limited to external whitening, once per arch in a 24-month period	Not Included		

*States availability subject to change



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Please refer to your plan documents for a complete list of limitations and exclusions. Plan documents are the final arbiter of coverage.

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