[COMPANY NAME]
[MARKET]
[Standard Stand-Alone Dental Plan]
SCHEDULE OF BENEFITS

Plan Overview		**In-Network Member Pays**	**Out-of-Network Member Pay**
Deductible			
Per covered person		$60	[ ]
Per Family (up to 3 family members)		$180 max	[ ]
Pediatric Benefits - For covered dependents under age 26			
Out-of-Pocket Maximum - *Out-of-Pocket Maximums do not apply to adult benefits.*			
For one child		$350	None
Two or more children		$700	None
Diagnostic and Preventive Services	Limitations		
Oral Exams	Twice per year	$0 copay. Deductible does not apply.	[ ]
X-Rays			
Periapicals	Four per year		
Bitewing Radiographs	Once every year		
Panoramic or Complete Series	Once every three years		
Cleanings	Twice per year		
Periodontal Scaling and Root Planing			
Periodontal Maintenance	Once every 3 months following periodontic surgery		
Fluoride	Twice per year		
Sealants			
Basic Services	Limitations		
Fillings		20% coinsurance after plan deductible is met	[ ]
Simple Extractions			
Major Services	Limitations		
Surgical Extractions		40% coinsurance after plan deductible is met	[ ]
Endodontic Therapy (Root Canal Treatment)			
Periodontal Therapy			
Crowns and Cast Restorations			
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)			
Other Services	Limitations		
Medically Necessary Orthodontic Services		50% coinsurance after plan deductible is met	[ ]
Adult Benefits – For covered persons aged 26 or above			
Plan Maximum – *Plan Maximums do not apply to pediatric benefits.*			
Plan Maximum per covered person – Combined for In-Network and Out-of-Network Services)		$2,000	
Diagnostic and Preventive Services	Limitations		
Oral Exams	Twice per year	$0 copay. Deductible does not apply.	[ ]
X-Rays			
Periapicals	Four per year		
Bitewing Radiographs	Once every year		
Panoramic or Complete Series	Once every three years		
Cleanings	Twice per year		
Periodontal Scaling and Root Planing			
Periodontal Maintenance	Once every 3 months following periodontic surgery		
Fluoride	Not Covered		
Sealants	Not Covered		

[COMPANY NAME]
[MARKET]
[Standard Stand-Alone Dental Plan]
SCHEDULE OF BENEFITS

Plan Overview		**In-Network Member Pays**	**Out-of-Network Member Pays**
Adult Benefits (continued) – For adults aged 26 or above			
Basic Services	Limitations		
Fillings		20% coinsurance after plan deductible is met	[ ]
Simple Extractions			
Major Services	Limitations		
Surgical Extractions		40% coinsurance after plan deductible is met	[ ]
Endodontic Therapy (Root Canal Treatment)			
Periodontal Therapy			
Crowns and Cast Restorations			
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)			
Other Services	Limitations		
Medically Necessary Orthodontic Services		Not Covered. 100% member cost share	[ ]

Waiting Periods – *Waiting periods do not apply to pediatric benefits.*	
Diagnostic and Preventive Services	No waiting period
Basic Services	6 months^
Major Services	12 months^
^Waiver of waiting period available with proof of prior coverage for these services under a dental insurance plan when the termination date was no more than 30 days prior to the effective date of this plan.	

Important information

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