[COMPANY NAME]
[MARKET]
[Standard Stand-Alone Dental Plan]

SCHEDULE OF BENEFITS

Plan Overview		In-Network Member Pays	Out-of-Network Member Pays
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 every 12 months	$0 copay. Deductible does not apply.	[ ]
Periapical X-Ray			
Bitewing X-Ray Series	Once every 12 months		
Panoramic X-Ray or Complete Series	Once every 36 months		
Cleanings	Twice every 12 months		
Fluoride			
Sealants	Once per 36 months. Ages 5-14 on 1st and 2nd molars		
Basic Services	Limitations		
Fillings		20% coinsurance after deductible	[ ]
Simple Extractions			
Major Services	Limitations		
Surgical Extractions		40% coinsurance after deductible	[ ]
Endodontic Therapy (Root Canal Treatment)			
Periodontal Therapy			
Periodontal Scaling and Root Planing	Once per quadrant per 36 months		
Periodontal Maintenance	Twice every 12 months		
Crowns and Cast Restorations			
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)			
Other Services	Limitations		
Medically Necessary Orthodontic Services		50% coinsurance after deductible	[ ]
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 every 12 months	$0 copay. Deductible does not apply.	[ ]
Periapical X-Ray	Four every 12 months		
Bitewing X-Ray Series	Once every 12 months		
Panoramic X-Ray or Complete Series	Once every 36 months		
Cleanings	Twice every 12 months		
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 deductible	[ ]
Simple Extractions			
Major Services	Limitations		
Surgical Extractions		40% coinsurance after deductible	[ ]
Endodontic Therapy (Root Canal Treatment)			
Periodontal Scaling and Root Planing	Once per quadrant per 36 months		
Periodontal Maintenance	Twice every 12 months		
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

[ ] indicate fields that are editable by Issuer.