

Highlights of your Dental Coverage

PBCBSAK Political Subdivision - APS

Effective Date: 07/01/2018

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	2018 DENTAL STANDARD 1500
COVERED SERVICES	
Individual/Family Deductible PCY	\$0 PCY / \$0 PCY
Diagnostic/Preventive	Covered In Full
-cleanings (limited to 2 PCY) -emergency exams (limited to 1 PCY) -fluoride treatments (limited to 2 applications PCY, age limits apply) -routine oral exams (limited to 2 PCY) -sealants (age limits apply) -space maintainers (age limits apply) -x-rays (including bitewing x-rays; complete series or panoramic X-ray once per 36 consecutive months)	
Basic	Deductible, then 20%
-emergency palliative treatment -endodontic (root canal) treatment (limited to 2 per arch when performed in conjunction with overdentures) -fillings (limited to once per tooth surface every 24 consecutive months) -full mouth debridement (limited to once every 3 calendar years) -general anesthesia (limited to covered dental procedures at a dental-care provider's office when dentally necessary) -oral surgery (including simple and surgical extractions) -periodontal maintenance (limited to 4 visits per calendar year) -periodontal scaling (limited to once per quadrant every 2 calendar years) -periodontal surgery	
Major	Deductible, then 50%
-dentures, partial & fixed bridges (replacements limited to once every 5 calendar years) -inlays, onlays & crowns (replacements limited to once per tooth every 5 years) -recementing & repair of crowns, inlays, bridgework & dentures	
Annual Maximum	\$1,500 PCY

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This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

