

## Exchange Certified Family Plan

<b>Annual Deductible</b>	<b>\$50</b>	Limit of 3 per family per benefit period
<b>Annual Maximum Benefit</b>	<b>Unlimited</b>	For covered individuals under age 19
	<b>\$2,000</b> [Includes MaxOver benefit, refer to Rate Summary for details]	For covered individuals age 19 and over
<b>Annual Maximum Out-of-Pocket</b>	<b>\$700 for one individual</b> <b>\$1,400 for two or more individuals</b>	For covered individuals under age 19
<b>Medically Necessary Orthodontic Maximum</b>	<b>Unlimited</b>	For covered individuals under age 19
<b>Coverage</b>	<b>PPO   Premier   OON</b>	<b>Benefit Limitations</b> Please refer to Plan Provisions for more detail on the limitations and exclusions.
<b>Diagnostic and Preventive Services (Type I)</b>  Oral exams and cleanings  Fluoride applications  Sealants  Bitewing and full mouth radiographic images  Space maintainers  <i>Healthy Smile, Healthy You<sup>®</sup></i> Program (For covered individuals age 19 and older)	<b>100%   100%   100%</b>	<b>No deductible applies</b>  Twice in a 12 month period.  Twice in a 12 month period.  For 1 <sup>st</sup> and 2 <sup>nd</sup> permanent molars, one application per tooth.  Bitewing - one set in a 12 month period. Full mouth - limited to one each 3 years.  One per missing tooth space.  Covered individuals who have certain high risk cardiac conditions, are pregnant, diabetic, and/or undergoing radiation or chemotherapy treatment for cancer are entitled to an additional exam and cleaning (or periodontal maintenance visit, if the individual has a history of periodontal surgery). Cancer patients are also entitled to an additional fluoride application beyond the age limitation of the group contract.
<b>Basic Dental Services (Type II)</b>  Amalgam and composite fillings  Prefabricated stainless steel crowns  Simple and surgical extractions  Endodontic/Periodontic	<b>80%   80%   80%</b>	<b>Deductible applies.</b>  Once in a 12 month period.  Allowed on primary (baby) teeth, once in a 24 month period.  See Plan Provisions for limitations and exclusions applicable to these benefits.
<b>Major Dental Services (Type III)</b>  Crowns  Prosthodontics/dentures/bridges  Denture repair and recementation of crowns, bridges and dentures	<b>50%   50%   50%</b>	<b>Deductible applies.</b>  Once per tooth every 5 years when an existing crown cannot be rendered serviceable and tooth cannot be restored by an amalgam or composite restoration.  Once every 5 years when an existing prosthesis cannot be rendered serviceable.  Once in a 12 month period after six (6) months from initial placement.
<b>Medically Necessary Orthodontic Benefits (Type IV)</b>	<b>50%   50%   50%</b>	<b>No deductible applies.</b> Medical criteria applies. See Plan Provision section for limitations and exclusions applicable to these benefits.