

**CONTRACTED****In-Network**

When using contracted providers, you are responsible to pay the amounts in this column

WAITING PERIODS**FUNDAMENTAL**

Preventive and Diagnostic	None
Basic	6 months
Major	12 months
Missing Tooth ¹	36 months

Any treatment, supply, or service received during the waiting period is not covered.

ANNUAL MAXIMUM PLAN PAYMENT**FUNDAMENTAL**

Annual maximum plan payment - per calendar year	Individual \$1,500
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DENTAL DEDUCTIBLE**FUNDAMENTAL**

Deductible - per calendar year	Individual/Family \$50/\$150
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PREVENTIVE AND DIAGNOSTIC**FUNDAMENTAL**

Oral examinations - two per calendar year Cleanings - two per calendar year X-rays - Panoramic or complete intraoral - once every 36 months - Bitewing - Under 18 two per calendar year; 18 and older one time per calendar year Sealants - covered under age 15, limited to permanent molars and bicuspid without decay or restorations. Sealant repair/replacement is not covered within 36 months of application Space maintainers - covered under age 15 Fluoride - two applications per calendar year, covered under age 18	10%
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BASIC**FUNDAMENTAL**

Fillings and restorations (repair or replacement is not covered within 24 months of original filling or restoration) Extractions Anesthesia and sedation - Local anesthesia not in conjunction with operative or surgical procedures; Regional block anesthesia; Trigeminal division block anesthesia Oral surgery Emergency care for pain relief	30% after deductible
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MAJOR

FUNDAMENTAL

Anesthesia and sedation - Deep Sedation; IV conscious sedation; Non-IV conscious sedation
 Dentures ²
 - Rebasing - once every 36 months
 - Relining - once every 18 months
 Bridges ²
 Veneers ³
 Crowns and crown buildups ³
 Inlays, onlays, and cast restorations ³
 Endodontic services - repeat endodontic procedures not covered within 12 months of the original procedure when performed by the same provider
 Periodontal treatment
 - Periodontal surgery - once per quadrant every 36 months
 - Debridement - once every 36 months
 - Scaling/root planing - once per quadrant every 24 months
 - Localized delivery of anti-microbial agents via controlled release vehicle (Arestin) - procedure should not exceed three teeth per quadrant or 30% of the mouth per calendar year.
 Periodontal maintenance - two times per calendar year, in lieu of cleanings

50% after deductible

ORTHODONTICS

FUNDAMENTAL

Orthodontic services

Not Covered

IMPLANTS

FUNDAMENTAL

Implants ²

Not Covered

FOOTNOTES

08/19/21

1 Services to replace teeth that were missing (with no restoration or prosthetic in place) prior to the member's effective date are not covered during the missing tooth waiting period.

2 Replacement of bridges, dentures, implants, or other prosthodontic devices due to normal wear or use, loss of remaining teeth, or change in supporting tissue, is covered only after five years from the date of placement. Repair and/or adjustment of bridges, dentures, implants, or other prosthodontic devices due to normal wear or use is covered only after six months from the date of placement. Replacement or repair due to abuse, misuse, neglect, loss, or theft is not covered.

3 Replacement is not covered within 5 years of placement.

You are responsible to pay any excess charges for covered services. Participating providers accept our allowed amount for covered services. This means you will not be responsible for charges that exceed this amount. Nonparticipating providers may charge more than our allowed amount, leaving you responsible for the additional costs. These providers may or may not bill SelectHealth for you. If not, you will be responsible to submit your claim. Refer to your plan documents or call Member Services at 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m. and Saturdays, from 9:00 a.m. to 2:00 p.m. for more information.

Benefits are administered by SelectHealth, Inc.SM (domiciled in Utah) and underwritten by SelectHealth Benefit Assurance CompanySM