



**Dental Coverage Summary**  
United Concordia Advantage Plus Network

| Dental Benefit Coverage                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | In-Network                                                                                                                                                                                                                                                                                                                                                                                                     | Out-of-Network Reimbursement                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <u><b>Diagnostic/Preventive</b></u><br>Routine Oral Examinations and Cleanings<br><i>- twice during a 12 month consecutive period</i><br>Routine Bitewing X-rays<br><i>- twice during a 12 month consecutive period</i><br>Full Mouth X-rays<br><i>- once every 36 months</i>                                                                                                                                                                                                                                                                            | <b>Covered at 100%</b><br>(100% of MAC*)                                                                                                                                                                                                                                                                                                                                                                       | <b>100%</b>                                                                                                                                           |
| <u><b>Dental Services</b></u><br>Basic Restorations - Amalgams, synthetic porcelain & plastic fillings<br>Major Restorative - Inlays, onlays, single crowns (caps)<br>Oral Surgery - Extraction and oral surgery procedures<br>Endodontics - pulpal therapy and root canal filling<br>Periodontics - Surgical & non-surgical treatment of gum disease<br>Prosthodontics - Construction & repair of dentures, bridges and partials<br>Denture Repair<br>Denture Relining - Relining existing dentures<br>Orthodontics (Dependent Children to age 19 Only) | <b>Covered at 100%</b><br>(100% of MAC*)<br><br><b>Covered at 50%</b><br>(50% of MAC*)<br><br><b>Covered at 100%</b><br>(100% of MAC*)<br><br><b>Covered at 100%</b><br>(100% of MAC*)<br><br><b>Covered at 100%</b><br>(100% of MAC*)<br><br><b>Not Covered</b><br><br><b>Covered at 100%</b><br>(100% of MAC*)<br><br><b>Covered at 100%</b><br>(100% of MAC*)<br><br><b>Covered at 50%</b><br>(50% of MAC*) | <b>100%</b><br><br><b>50%</b><br><br><b>100%</b><br><br><b>100%</b><br><br><b>Not Covered</b><br><br><b>100%</b><br><br><b>100%</b><br><br><b>50%</b> |
| <u><b>Program Deductibles &amp; Maximums</b></u><br>Contract Year Deductible<br>Contract Year Program Maximum Benefit Payments<br>Lifetime Orthodontic Maximum Benefit Payments                                                                                                                                                                                                                                                                                                                                                                          | <b>N/A</b><br><br><b>\$1,500 Per Person</b><br><br><b>\$1,650 Per Dependent Child</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                       |

\*MAC - Maximum Allowable Charge of United Concordia. In-network claims are reimbursed at a negotiated rate.

Out-of-Network Reimbursement pays at Providers Charge.

\*\* For full plan details please refer to the Summary Plan Description.