

# 1. What You Pay

This section is intended to provide you with an overview of your payment obligations under this group health plan. This section is not intended to be and does not constitute a complete description of your payment obligations. To understand your complete payment obligations you must become familiar with this entire coverage manual, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

## Payment Summary

This chart summarizes your payment responsibilities. It is only intended to provide you with an overview of your payment obligations. It is important that you read this entire section and not just rely on this chart for your payment obligations.

| Category   | Deductible                          | Coinsurance | Benefit Year Maximum | Lifetime Maximum |
|--|-------------------------------------|-------------|----------------------|------------------|
| <b>All Services</b>                              | \$25 per person<br>\$75 per family* |             | \$1,000              |                  |
| <b>Oral Evaluations</b>                          | waived                              | 0%          |                      |                  |
| Preventive Evaluations (check-ups)               |                                     |             |                      |                  |
| Problem-Focused Evaluations                      |                                     |             |                      |                  |
| Dental Cleaning                                  |                                     |             |                      |                  |
| Fluoride Applications                            |                                     |             |                      |                  |
| X-rays   |                                     |             |                      |                  |
| Periodontal Maintenance                          |                                     |             |                      |                  |
| Therapy  |                                     |             |                      |                  |
| Sealant Applications                             |                                     |             |                      |                  |
| Space Maintainers                                |                                     |             |                      |                  |
| <b>Cavity Repair</b>                             |                                     | 20%         |                      |                  |
| Contour of Bone                                  |                                     |             |                      |                  |
| Emergency Treatment                              |                                     |             |                      |                  |
| General Anesthesia                               |                                     |             |                      |                  |
| Limited Occlusal Adjustment                      |                                     |             |                      |                  |
| Routine Oral Surgery                             |                                     |             |                      |                  |
| <b>Root Canals and Other Endodontic Services</b> |                                     | 20%         |                      |                  |
| Apicoectomy                                      |                                     |             |                      |                  |
| Direct Pulp Cap                                  |                                     |             |                      |                  |
| Pulpotomy  |                                     |             |                      |                  |
| Retrograde Fillings                              |                                     |             |                      |                  |
| Root Canal Therapy                               |                                     |             |                      |                  |
| <b>Treatment of Gum and Bone Diseases</b>        |                                     | 50%         |                      |                  |
| Conservative Procedures                          |                                     |             |                      |                  |
| Complex Procedures                               |                                     |             |                      |                  |
| <b>High Cost Restorations</b>                    |                                     | 50%         |                      |                  |
| Crowns   |                                     |             |                      |                  |
| Inlays   |                                     |             |                      |                  |
| Onlays   |                                     |             |                      |                  |
| Posts and Cores                                  |                                     |             |                      |                  |

| Category  | Deductible | Coinsurance | Benefit Year Maximum | Lifetime Maximum |
|---|------------|-------------|----------------------|------------------|
| <b>Dentures and Bridges (Prosthetics)</b><br>Bridges<br>Dentures<br>Dental Implants |            | 50%         |                      |                  |
| <b>Orthodontics</b>   |            | 50%         | waived               | \$1,000          |

\*Family amounts are reached from amounts accumulated on behalf of any combination of covered family members.

## Payment Details

### Deductible

Deductible is the fixed dollar amount you pay for covered services in a benefit year before Blue Dental benefits become available.

The family deductible is reached from amounts accumulated on behalf of any combination of covered family members.

Once you meet the deductible, then coinsurance applies.

### Coinsurance

Coinsurance is the amount, calculated using a fixed percentage, you pay each time you receive covered services. Coinsurance amounts apply after you meet the deductible for the benefit year.

### Benefit Year Maximum

This is the maximum payment amount each member is eligible to receive for certain covered services in a benefit year.

The benefit year maximum is reached from claims settled under this benefits plan during a benefit year.

### Lifetime Maximum

In a member's lifetime, total benefits are limited by a dollar amount for benefit category *Orthodontics*.