

***Shawnee State University
Anthem Dental PPO (group size 51+)
Summary of Benefits, effective 01/01/2018***

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Dental Certificate.

BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)
Annual Deductible (Single/Family)	\$50/\$150 Network and Non-network combined
Annual Maximum	\$1,000 Network and Non-network combined
DIAGNOSTIC/PREVENTIVE	Covered in full* Network and Non-network
Diagnostic and Preventive Services (no deductible) <ul style="list-style-type: none"> oral evaluations X-rays cleanings space maintainers other selected diagnostic and preventive services 	
GENERAL/RESTORATIVE	20% Network/20% Non-network
General (Adjunctive) Services (deductible applied) <ul style="list-style-type: none"> emergency palliative treatment consultations general anesthesia (surgical procedures) I.V. sedation (surgical procedures) office visits for observation other selected general services Restorative Services (deductible applied) <ul style="list-style-type: none"> amalgam and composite restorations pin retention procedures 	
SPECIALTY	20% Network/20% Non-network
Endodontic Services (deductible applied) <ul style="list-style-type: none"> root canal therapy apexification therapeutic pulpotomy other selected endodontic services Oral Surgery Services (deductible applied) <ul style="list-style-type: none"> simple and surgical tooth extractions other selected oral surgery services Periodontal Services (deductible applied) <ul style="list-style-type: none"> gingivectomy crown lengthening osseous surgery soft tissue grafts other selected periodontal services 	
PROSTHODONTIC	50% Network/50% Non-network
Prosthodontic Services (deductible applied) <ul style="list-style-type: none"> crowns/onlays partial and full dentures other selected prosthodontic services Missing Tooth Benefit <i>Services for the replacement of teeth (tooth) lost prior to the member's effective date of coverage under this plan.</i> <ul style="list-style-type: none"> removable prosthodontics (partials or dentures) fixed prosthodontics (bridges) for the replacement of teeth (or tooth) 	Covered
ORTHODONTIC	Child and Adult to maximum dependent age:
Orthodontic Services (no deductible) <ul style="list-style-type: none"> non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth examination records tooth guidance repositioning (straightening) of the teeth 	40% Network/40% Non-network

(continued on back)

BENEFITS

Separate Orthodontic Lifetime Maximum

NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)

\$1,000 Network and Non-network combined

Note: A waiting period may apply. Please refer to your Dental Certificate for additional information.

**When choosing a Non-network provider, the member is responsible for any balance due after the plan payment, including but not limited to, benefits that are covered in full.*

Dependent age: to end of month age 26.