ConnectiCare Dental Plans

ConnectiCare Insurance Company, Inc.

Premium: $1,000 Maximum, Without Orthodontic Coverage

DENTAL PLAN BENEFITS SUMMARY

Participating Provider (In-Network Level Of Benefits	Non-Participating Provider (Out-of-Network Level Of Benefits)*	Care Category	Procedure Code	Description By Illustration, Not By Limitation
100%	100%	Diagnostic	00100-00199 00331-00999	Oral examination, diagnostic casts.
100%	100%	X-Rays	00200-00330	Complete mouth x-rays, periapical x-rays, bitewing x-rays, panoramic x-rays.
100%	100%	Preventive	01000-01999	Prophylaxis, fluoride applications, space maintainers.
80%	80%	Restorative**	02000-02399	The treatment of tooth decay by the use of amalgam and/or composite restorations.
50%	50%	Restorative-Crowns**	02400-02999	The use of gold, semiprecious, or nonprecious metals to restore a tooth or teeth which cannot be restored with amalgam or composite restorations.
80%	80%	Endodontics**	03000-03999	The treatment of the diseases of the nerve of the tooth.
50%	50%	Periodontics**	04000-04999	The treatment of the supporting tissues of the teeth, gums, and underlying bone, with either surgical or non surgical procedures (where applicable).
50%	50%	Prosthetics – Removable**	05000-05399 05600-05899	The replacement of missing teeth by the use of a removable appliance.
80%	80%	Prosthetics - Adjustment**	05400-05799	The repair or modification of existing removable and/or fixed appliances so that they can continue to be serviceable.
50%	50%	Prosthetics – Fixed, Implants**	06000-06999	The use of gold, semiprecious, precious metals or implants to replace a missing tooth or teeth, which cannot otherwise be replaced with a removable appliance.
80%	80%	Extractions**	07000-07219 07250-07999	The extraction, either simple or surgical, of either a single tooth or multiple teeth, the shaping of bone ridges, the removal of a tooth end abscess, etc.
50%	50%	Bony Impactions**	07220-07249	The surgical removal of teeth partially or fully covered by bone.
0%	0%	Orthodontics**	08000-08999	The straightening of teeth for dental health reasons.
80%	80%	General Services**	09000-09999	All other adjunctive general services as coded in the American Dental Association (ADA) Current Dental Terminology, which are not included in the specific categories listed, that are covered services.

DEDUCTIBLES AND MAXIMUMS

Participating Provider (In-Network Level Of Benefits	Non-Participating Provider (Out-of-Network Level Of Benefits)	
$1,000		Annual Maximum Per Individual
$50.00		Annual Deductible Per Individual
$150.00		Annual Deductible Per Family
$0.00		Orthodontic Lifetime Maximum Per Individual

Benefit year effective date: July 1, 2015

As used herein, "Annual" means the benefit year in which dental care services are performed.
*For those subscribers and their families electing to be served by a non-participating provider; submitted claims will be processed at any time during the benefit year and reimbursements will be made at the level of coverage listed under "Non-Participating Provider (Out-Of-Network Level of Benefits)" and in amounts up to the schedule of allowances paid to participating provider. Payments will be limited to the individual annual maximum listed above or that portion of the individual annual maximum, which may be remaining if care had previously been provided during the benefit year by a participating provider, subject to the plan's deductibles and standard exclusions and limitations.
** Care Category (ies) of coverage the deductible applies to.