

# 2016 DENTAL

	FLEXIBLE PLAN	LIMITED PLAN
	In-Network <sup>1</sup> (out-of-network coverage available)	In-Network Only <sup>1</sup> (no out-of-network coverage)
<b>Annual Deductible</b>	\$75/person; \$225/family	\$0
<b>Plan pays...</b>		<b>See schedule of benefits for cost by service<sup>2</sup></b>
Preventive/Diagnostic (2 exams/cleanings every 12 months, x-rays, sealants, fluoride)	100%; no deductible	100% for most services
Basic Restorative (fillings, extractions, oral surgery, root canals, periodontics)	80%; no deductible	100% for some services; you pay flat fee for other services
Major Restorative (crowns, bridges, dentures, implants)	50% after deductible	You pay flat fee for most services; implants not covered
Orthodontia (child and adult)	50% after annual deductible <u>and</u> one-time \$100 orthodontia deductible	You pay flat fee for most services
Lifetime Orthodontia Maximum	\$1,000/person	See schedule of benefits <sup>2</sup>
TMJ (temporomandibular joint) Treatment	50% after annual deductible <u>and</u> \$100 annual TMJ deductible	Not covered
Lifetime TMJ Maximum	\$750/person	N/A
Annual Benefit Maximum	\$1,000/person (excludes orthodontia, TMJ)	N/A

<sup>1</sup> If there is no network provider within a 30-mile radius of your home, you may use an out-of-network provider and receive in-network benefits. Contact BCBS for instructions.

<sup>2</sup> View the Limited Plan schedule of benefits at [bcbst.com/members/metro-gov/dental](http://bcbst.com/members/metro-gov/dental).