ConnectiCare

Dental Plans for SOLO members

Dental Cost-Sharing

	In-Network	Out-of-Network
Annual Individual Deductible - Applies to Type B:	$25	$25
Combined Family Maximum - Applies to Type B:	$75	$75
Coinsurance - Type A:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Coinsurance - Type B:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Annual Maximum - Includes Type A, B:	Unlimited	Unlimited
Basic Services - Type B:	Includes Basic Restorations Only	Includes Basic Restorations Only
Major Services:	Not Included	Not Included
Orthodontic Services:	Not Included	Not Included

Type A - Preventive and Diagnostic Services

	Limitations	In-Network	Out-of-Network
Prophylaxes	Two (2) scaling, cleaning and polishing treatments per member per calendar year.	Not subject to Deductible Type A Coinsurance Only	Not subject to Deductible Type A Coinsurance Only
Fluoride Treatments	One (1) fluoride treatments per covered child until age 19 EOY per calendar year.	Not subject to Deductible Type A Coinsurance Only	Not subject to Deductible Type A Coinsurance Only
Examinations	One (1) routine examination per member per calendar year. One (1) initial comprehensive oral evaluation per dentist per member lifetime.	Not subject to Deductible Type A Coinsurance Only	Not subject to Deductible Type A Coinsurance Only
X-Rays	Four (4) bitewing x-rays per member per calendar year. One (1) full-mouth series of X-rays or one (1) panoramic film once every three (3) years.	Not subject to Deductible Type A Coinsurance Only	Not subject to Deductible Type A Coinsurance Only
Space Maintainers	One (1) space maintainer per covered child until age 13 EOY once per quarter or arch per lifetime.	Not subject to Deductible Type A Coinsurance Only	Not subject to Deductible Type A Coinsurance Only
Sealants	One (1) sealant per covered tooth every three (3) calendar years per covered child age 5 until age 14 birthdate.	Not subject to Deductible Type A Coinsurance Only	Not subject to Deductible Type A Coinsurance Only

Type B - Basic Restorations

	Limitations	In-Network	Out-of-Network
Basic Restorations	Fillings, exlcudes temporary fillings, covered every six (6) months.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance

Benefits are subject per member per calendar year

For those subscribers and their families electing to be serviced by Out-of-Network providers; submitted claims will be processed at any time during the calendar year and reimbursements will be made at the level of coverage listed under "Out-of-Network" and in amounts up to the schedule of allowances paid to participating providers. Payments will be limited to the individual annual maximum listed in the annual maximum section. These benefits may be subject to the plans deductibles and are subject to the plans exclusions and limitations.