JANUARY 1 – DECEMBER 31, 2025

SUMMARY OF BENEFITS

PARAMOUNT **DENTAL**

Preventive Family Plan

PARAMOUNT DENTAL
Affiliate of ProMedica

Y0140_2023004SB_M

Summary of Dental Plan Benefits

This Summary of Dental Plan Benefits is provided by Paramount Dental, for some of the more frequently performed dental procedures. This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Paramount Dental plan, including plan exclusions and limitations. If a statement in this Summary of Dental Plan Benefits conflicts with a statement in the Certificate, the statement in this Summary of Dental Plan Benefits applies to you and you should ignore the conflicting statement in the Certificate.

Group Number: Preventive Family Plan

Plan Annual Maximum	**None**
Deductible (waived for preventive and diagnostic services)	**Adults: None / Pediatric: $25**

Diagnostic & Preventive	**Adult In Network***	**Pediatric In Network***
Evaluation: periodic, limited, comprehensive	100%	100%
Teeth Cleaning (prophylaxis)	100%	100%
Fluoride - topical application or varnish.	100%	100%
X-Rays - bitewings, periapical, panoramic	100%	100%
X-Rays - vertical bitewings, full mouth	0%	100%
Sealants	0%	100%
Space Maintainer: fixed & removable	0%	100%
Basic (6 month waiting period for members 19 and older)		
Minor Restorative	*Fillings – silver/amalgam or white/composite (anterior and posterior teeth)*	0%	50%
Endodontic	*Root canal therapy – includes periapical x-rays, cultures, follow-up care, treatments and pulpotomy*	0%	50%
Periodontic	*Scaling & root planning*	0%	50%
Prosthodontic	*Relining, rebasing, repairs, replacement of teeth and adjustments.*	0%	50%
Oral Surgery	*Extractions*	0%	50%
Adjunctive	*Emergency palliative treatment*	0%	100%
	Anesthesia – general and IV sedation, nitrous	0%	50%
	Teledentistry (2 visits per year)	100%	100%
Major (9 month waiting period for members 19 and older)		
Major Restorative	*Crowns, Inlays, Onlays, Core Buildup*	0%	50%
	Inlays, Onlays, Post, Recementation and Repairs	0%	50%
Endodontic	*Apexification, Apicoectomy*	0%	50%
Periodontics	*Gingivectomy, gingivoplasty, gingival flap, osseous and clinical crown lengthening.*	0%	50%
Prosthodontic	*Bridges, partial and complete dentures*	0%	50%
Oral Surgery	*Surgical Extractions including impactions, eruption*	0%	50%
	Alveoloplasty, and other surgical procedures	0%	50%

Medically Necessary Pediatric Orthodontic – see definition on page 2)		
Implant Services including placement and abutments and other related services	0%	50%
Orthodontic Services (braces) – Child (under 19)	0%	50%

***In Network** dentists have agreed to accept contracted maximum allowable fees on covered dental services. Your co-insurance percentage is based on that contracted fee. Therefore, your benefit dollars will go further and your out of pocket costs will likely be less when you visit a network dentist.

****Out of Network** dentists are under no obligation to accept contracted fees. When dental services are received from a non-contracted dentist, the percentages in this column indicate the portion of Paramount Dental's non-participating dentist fee schedule (allowed amount) that will be paid for those services. This fee schedule allowed amount may be less than the dentist's charge and you will be responsible for that dollar difference and your co-insurance percentage.

- Oral evaluations are payable 2 per 12 consecutive month period beginning at eruption of the first tooth, but no later than 12 months of age.
- A routine teeth cleaning (prophylaxis) is payable 2 per 12 consecutive month period regardless of the dentist's specialty, unless performed within 6 months of periodontal scalings and root planing, periodontal full mouth debridement, or periodontal maintenance.
- Fluoride treatment excluding varnish is payable once per 6 months. Including varnish is payable once per 6 months. Including varish is payable 4 times per Benefit Plan Year for dependents age 0 - 2.
- Bitewing x-rays are payable to a maximum of 4 films in a 12 month period. Full mouth x-ray or Panoramic film are payable once per 4 years. The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a full mouth x-ray. The difference may not be billed to the Enrollee.
- Sealants are payable once per 3 years for permanent molar teeth only and for dependents under 19 years of age.
- A restoration (amalgam or resin-based composite) is payable once in any 2 year period per tooth for anterior and posterior teeth.
- A core buildup will not be payable if performed within 3 years of restoration and/or replacement within 5 years on the same tooth. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo.
- Replacement of crowns are payable per tooth every 5 years.
- Root canal treatment includes periapical x-rays, cultures, follow up care, treatments, pulpotomy.
- A periodontal scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable once in any 2 year period per quadrant and subject to the submission of full mouth probe chart with six points per tooth probings and diagnostic full mouth radiographs and/or vertical bitewings to determine if procedure meets plan criteria. A pretreatment estimate is recommended to determine coverage.
- Implants/Implant related services are payable once per tooth in any 5 year period.
- Replacement of dentures, partial dentures, and fixed bridges are payable once per 5 years.
- Teledentistry visit is allowable twice per 12 month period

Orthodontic Services (Pediatric Medically Necessary Only) – Orthodontic services are covered for children under 19 years of age and is only covered for children with significant impairment as a result of craniofacial abnormalities, malocclusions, caused by trauma, or congenital disharmonies that affect daily ability to function, like speaking and eating. Must be preauthorized.

Deductible – $0 for adults and **$25** for dependents under 19 years of age, per Benefit Plan Year. The deductible does not apply to diagnostic and preventive services. Please reference your Master Group Policy for your Benefit Deductible methodology definition.

Plan Annual Maximum – There is no Plan Annual Maximum for this Benefit Plan.

Benefit Plan Year – The Plan will expire at the end of calendar year for which the Enrollee and their dependents have enrolled in.

Out-of-Pocket Maximum for Pediatric Dental Care – $425 per Benefit Plan Year for one child, **$850** per Benefit Plan Year for two or more children. Please reference your Policy for your Out-of-Pocket Maximum methodology definition.

Eligibility – You and, if applicable, your legal spouse (or domestic partner) and your children who meet the dependent age requirements are eligible on the policy effective date.

Dependent Age Limit – Dependent coverage includes children up to age 26, regardless of any, or a combination of any, of the following factors: financial dependency, residency, student status, employment status, or marital status.

Waiting Period for Covered Services – There are no waiting periods on this Benefit Plan. The waiting Period for Covered Services does not apply to pediatric dental care.

Out of Network Reimbursement – There are no out of network reimbursements on this plan.

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