Dental Benefit Summary

	Plan 1 In/Out Network	Plan 2 In/Out Network	Basic In/Out Network	Enhanced In/Out Network	Dental HMO
Network	Any dentist	Any dentist	Any dentist	State of CT DPPO	State of CT DHMO
Out of Network Coverage	Yes	Yes	Yes	Yes, low reimbursement(MAC)	No
Annual Deductible	$25 indiv/$75 family	None	None	$25 individual, $75 family	None
Annual Maximum per person	$1,000	$1,500	Unlimited	$3,000	Unlimited
Periodontal Care Maximum per person	Annual Max applies. No Annual max for periodontal cleanings, scaling & root planing.	Annual Max applies. No Annual max for periodontal cleanings, scaling & root planing.	$500 Annual Max except periodontal cleanings, scaling & root planing.	Annual max applies	Covered
Implant Maximum (per calendar year)	Not covered	Not covered	Not covered	$500	No dollar annual max, frequency max applies
Lifetime Maximum per person	$1,500	$1,500	Not covered	$1,500	None

CONNECTICUT 2.0 PARTNERSHIP PLAN

Dental Benefit Summary

	Plan 1 In/Out Network	Plan 2 In/Out Network	Basic In/Out Network	Enhanced In/Out Network	Dental HMO
DEDUCTIBLE WAIVED					
Preventative	Yes	Yes	Yes	Yes	Yes
Perio Cleaning	Yes	Yes	Yes	Yes	Yes
Orthodontia	Yes	N/A	No	Yes	Yes
PREVENTATIVE					
X-Ray	100%	100%	100%	100%	100%
Cleanings	100%	100%	100%	100%	100%
Oral Exam	100%	100%	100%	100%	100%
Fluoride	80%	100%	80%	100%	100%
Sealants	100%	100%	80%	100%	covered

CONNECTICUT PARTNERSHIP PLAN 2.0

Dental Benefit Summary

	Plan 1 In/Out Network	Plan 2 In/Out Network	Basic In/Out Network	Enhanced In/Out Network	Dental HMO
BASIC					
Fillings	80%	80%	80%	80%	copay applies
Emergency Care	80%	80%	80%	80%	covered
Endodontics	80%	80%	80%	80%	copay applies
Periodontal Cleaning	80%	80%	100%	100%	copay applies
Periodontal: All Other	50%	80%	50%	80%	copay applies
Denture, Bridge, Crown Repair	80%	80%	80%	80%	copay applies
Simple Extractions	80%	80%	80%	80%	copay applies
General Anesthesia	not covered	80%	not covered	80%	copay applies

CONNECTICUT PARTNERSHIP PLAN 2.0

Dental Benefit Summary

	Plan 1 In/Out Network	Plan 2 In/Out Network	Basic In/Out Network	Enhanced In/Out Network	Dental HMO
MAJOR					
Crown/Inlay/Onlay	50%	67%	67%	67%	copay applies
Dentures	0%	67%	not covered	50%	copay applies
Bridges	0%	67%	not covered	50%	copay applies
Space Maintainers	50%	100%	67%	80%	copay applies
Oral Surgery (non Simple Extractions)	50%	80%	67%	80%	copay applies
Implants	not covered	not covered	not covered	50%	copay applies
ORTHODONTIA					
Braces	50%	50%	not covered	50%	copay applies
Child and Adults	Yes	Child Only	not covered	Yes	Yes

CONNECTICUT 2.0 PARTNERSHIP PLAN