The Santa Maria-Bonita School District

Summary of Dental Benefits

	IN-NETWORK			OUT-OF-NETWORK	
I. Diagnostic & Preventive Services	**Coverage**	**Deductible**		**Coverage**	**Deductible**
	100%	Waived		80%	$25 per person $50 per family
~ Bitewing X-rays (once every six months for children to age 19; once every 12 months for adults over age 19)					
~ Full mouth X-rays (once in a three year period)					
~ Emergency palliative treatment					
~ Prophylaxis (twice/year)					
~ Fluoride treatment (once every 6 months to age 19)					
~ Space maintainers (to treat premature loss of primary teeth)					
~ Application of sealants (on permanent first and second molars with no restorations and the occlusal surface intact: first molars to age 9 and second molars up to age 14: does not include the repair or replacement of a sealant on any tooth within three years of application)					
II. Basic Services	**Coverage**	**Deductible**		**Coverage**	**Deductible**
	90%	$25 per person $50 per family		80%	$25 per person $50 per family
~ Crowns					
~ Restorations (amalgam, synthetic, plastic, or resin fillings)					
~ Periodontics					
~ Endodontics					
~ Oral surgery (extractions and certain other surgical procedures, including pre-and post- operative care)					
~ Sealants - topically applied acrylic, plastic or compsite material (only to permanent first and second molars without decay - First molars up to age nine and Second molars up to age 14. Does not include repair or replacement of sealant within three years of application)					

	IN-NETWORK			OUT-OF-NETWORK	
III. Jackets, Inlays, Onlays and Cast Restorations	**Coverage**	**Deductible**		**Coverage**	**Deductible**
	90%	$25 per person $50 per family		80%	$25 per person $50 per family
~ Crowns, jackets, inlays, and cast restorations are benefits only if they are provided to treat cavities that cannot be directly restored with amalgam, synthetic, plastic or resin fillings.					
Limitations: *The above benefits are on the same tooth only once every five (5) years while you are eligible under this program)*	On year waiting period for all new enrollees without prior dental coverage.			One year waiting period for all new enrollees without prior dental coverage.	
IV. Prosthodontic Benefits	**Coverage**	**Deductible**		**Coverage**	**Deductible**
	90%	$25 per person $50 per family		80%	$25 per person $50 per family
~ Construction or repair of fixed bridges, partial dentures, and complete dentures are benefits if provided to replace missing, natural teeth.					
Limitations: *A) Prosthodontic appliances are benefits only once every five (5) years while eligible under this program.* *B) SMBSD will pay the above percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance. This fee allowance is the fee that would satisfy the majority of Mid Coast's Dentists. A standard partial or complete denture is one made of exceptional materials. The maximum fee allowance is revised periodically as dental fees change, If your dentist's accepted fee is higher than this maximum allowance, you must pay that portion of the fee that exceeds the allowance in addition to your portion of the allowance.* *C) Implants are NOT covered by this program. (see more information in your full Summary of Plan Description)*					

	IN-NETWORK			OUT-OF-NETWORK	
V. Dental Accident Benefits	**Coverage** 100%	**Deductible** None		**Coverage** 100%	**Deductible** None
~ Any services which would be covered under other benefit categories (subject to the same limitations and exclusions) are covered instead by your dental accident coverage when they are provided for condidtions caused directly by external, violent accidental means. ~ Benefits are limited to a separate $1,000 maximum per calendar year					
Limitation: *SMBSD will pay Dental Accident Benefits when services are provided within 180 days following the date of accident and shall not include any services for conditions caused by an accident occurring before your eligibility date.*					
	IN-NETWORK			OUT-OF-NETWORK	
VI. Orthodontia	**Coverage** 50%	**Deductible** None		**Coverage** 0%	**Deductible** None
~ Coverage is for all eligible enrollees regardless of age.					
~ Lifetime Benefit of $2,000 per person					
~ Maximum benefit/person/calendar year	$2,000			$2,000	
~ Deductibles	$25 per person $50 per family			$25 per person $50 per family	
~ Orthodontia Lifetime Maximum	$2,000			$0.00	
~ Predetermination of benefits: When a course of dental treatment is expected to exceed $300, predetermination of benefits is recommended.	$300			$300	

** See your SPD for full disclosure	***A predetermination does not guarantee payment***		***A predetermination does not guarantee payment***