

Attachment A - Schedule of Benefits
Group I A & B

To receive benefits from this Plan, make sure the Provider is a member of the Provider Network. If you receive services from an Out-of-Network Provider, you will be responsible for the full payment of the Out-of-Network Provider's charge. **No Benefits are payable for services received from Out-of-Network Providers.**

Your dentist will tell you if a service is going to be paid by CoverKids or not before he or she treats you.

DENTAL BENEFITS	GROUP ONE A CHILD	GROUP ONE B CHILD
Preventive -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars, no limit -- 2 cleanings per calendar year	No co-payment	No co-payment
Diagnostic Services -- 2 oral exams per calendar year	No co-payment	No co-payment
Emergency Services -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	\$15 co-payment	\$15 co-payment
Restorative Services -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	\$15 co-payment	\$15 co-payment
Extractions	\$15 co-payment	\$15 co-payment
Radiographs -- Bitewing x-rays no more frequently than once per calendar year (2 years of age and older) -- Full mouth x-rays no more frequently than once every three calendar years	No co-payment	No co-payment
Therapeutic Pulpotomy	\$15 co-payment	\$15 co-payment
Anesthesia	\$15 co-payment	\$15 co-payment
Other Dental Services	\$15 co-payment	\$15 co-payment
Deductibles	None	None
Annual Benefit Maximum per child	\$600	\$600
Out of Pocket Maximum as a Percentage (%) of Annual Family Income	5%	Not applicable

Please note certain covered dental codes are subject to a \$600 annual benefit cap; therefore, requested reimbursement is determined by available member funds following claim submission and processing.



Attachment A - Schedule of Benefits

Group II

To receive benefits from this Plan, make sure the Provider is a member of the Provider Network. If you receive services from an Out-of-Network Provider, you will be responsible for the full payment of the Out-of-Network Provider's charge. **No Benefits are payable for services received from Out-of-Network Providers.**

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DENTAL BENEFITS	GROUP TWO CHILD
Preventive -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars, no limit -- 2 cleanings per calendar year	No co-payment
Diagnostic Services -- 2 oral exams per calendar year	No co-payment
Emergency Services -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	\$5 co-payment
Restorative Services -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	\$5 co-payment
Extractions	\$5 co-payment
Radiographs -- Bitewing x-rays no more frequently than once per calendar year (2 years of age and older) -- Full mouth x-rays no more frequently than once every three calendar years	No co-payment
Therapeutic Pulpotomy	\$5 co-payment
Anesthesia	\$5 co-payment
Other Dental Services	\$5 co-payment
Deductibles	None
Annual Benefit Maximum per child	\$600
Out of Pocket Maximum as a Percentage (%) of Annual Family Income	5%

Please note certain covered dental codes are subject to a \$600 annual benefit cap; therefore, requested reimbursement is determined by available member funds following claim submission and processing.

Attachment A - Schedule of Benefits
Group AI/AN

To receive benefits from this Plan, make sure the Provider is a member of the Provider Network. If you receive services from an Out-of-Network Provider, you will be responsible for the full payment of the Out-of-Network Provider's charge. **No Benefits are payable for services received from Out-of-Network Providers.**

Your dentist will tell you if a service is going to be paid by CoverKids or not before he or she treats you.

DENTAL BENEFITS	AMERICAN INDIAN/ ALASKAN NATIVE (AI/AN) CHILD
Preventive -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars, no limit -- 2 cleanings per calendar year	No co-payment
Diagnostic Services -- 2 oral exams per calendar year	No co-payment
Emergency Services -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	No co-payment
Restorative Services -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	No co-payment
Extractions	No co-payment
Radiographs -- Bitewing x-rays no more frequently than once per calendar year (2 years of age and older) -- Full mouth x-rays no more frequently than once every three calendar years	No co-payment
Therapeutic Pulpotomy	No co-payment
Anesthesia	No co-payment
Other Dental Services	No co-payment
Deductibles	None
Annual Benefit Maximum per child	\$600
Out of Pocket Maximum as a Percentage (%) of Annual Family Income	Not applicable

Please note certain covered dental codes are subject to a \$600 annual benefit cap; therefore, requested reimbursement is determined by available member funds following claim submission and processing.

