

BENEFIT SUMMARY

Polk County

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the benefits certificate or coverage manual you will receive after you enroll and the enrollment regulations in force when the certificate or manual becomes effective. Certain exclusions and limitations apply.

DENTAL PLAN BASICS	PPO	NON-PPO
Benefit year deductible single/family The fixed amount you pay for covered services before Wellmark makes a benefit payment; maximum of three deductibles per family per year.	\$15/\$45	\$25/\$75
Benefit year maximum The maximum amount each covered family member is eligible to receive for covered services in one benefit year.	\$1,250	
Lifetime orthodontics maximum The maximum amount each member is eligible to receive for covered orthodontia services.	\$1,500	

COVERED SERVICES	PPO	NON-PPO
Diagnostic and preventive Cleaning* (prophylaxis and periodontal maintenance), fluoride (under age 19), X-rays, topical sealant (under age 15) and space maintainers (under age 15)	0% coinsurance	0% coinsurance
Basic restorative Cavity repair, general anesthesia/sedation, emergency pain/infection relief	10% coinsurance	20% coinsurance
Oral surgery Basic and complex extractions, complex surgical procedures	10% coinsurance	20% coinsurance
Endodontics Root canals, retrograde fillings, apicoectomy/periradicular, direct pulp caps	20% coinsurance	20% coinsurance
Periodontics Gum & bone disease, non-surgical and complex surgical procedures	20% coinsurance	20% coinsurance
Major restorative Crowns, posterior composites, onlays, inlays, posts and cores	50% coinsurance	50% coinsurance

* Carry-Over Benefit is optional for all groups and allows members to carry-over a portion of unused annual maximum from one year to the next.
 Added benefits available to members with specific conditions. Forms must be submitted in advance and can be found at Wellmark.com/Forms.
 Please note: Added condition-specific benefits are automatically included for fully-insured groups. For self-funded, this benefit would be elected by the group at the time of enrollment.
 Deductible waived for diagnostic and preventive services. Maximum of three deductibles per family per calendar year.
 Benefits and general provisions described are subject to plan selected, and terms of the actual policy and coverage manual.

COVERED SERVICES	PPO	NON-PPO
Prosthodontics Dentures, partials, bridges, implants, repairs and adjustments	50% coinsurance	50% coinsurance
Orthodontics Services for the alignment of teeth	50% coinsurance	50% coinsurance

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).



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