

**Halifax Health — Dental**

Dental Benefits for Group W14 Effective 1/1/2022

Annual Deductible	
Class I — Preventive & Diagnostic Services	None
Class II — Basic & Restorative Services	
Class III — Major Services	
Class IV — Orthodontic Services	
Plan Benefit Maximums (Type I, II, III and IV combined)	Paid by the Plan:
Single	\$1,500 per person per calendar year
Family	\$4,200 per family per calendar year
Class I — Preventive & Diagnostic Services	
Oral exams, cleanings, bitewing X-rays <i>(no limitations)</i>	100% of the first \$250, then 50% of the fee schedule*
Full-mouth X-rays <i>(no limitations)</i>	
Fluoride applications <i>(no limitations)</i>	
Class II — Basic & Restorative Services	
Fillings, extractions, root canals, periodontics	100% of the first \$250, then 50% of the fee schedule*
Oral surgery, anesthesia, injections of antibiotics	
Repair of bridgework or dentures	
Relining of dentures <i>(no limitations)</i>	
Class III — Major Services	
Inlays, gold fillings, crowns, bridgework, implants	100% of the first \$250, then 50% of the fee schedule*
Class IV — Orthodontic Services	
Orthodontic procedures <i>(no limitations)</i>	100% of the first \$250, then 50% of the fee schedule*
*Fee Schedule does not apply to non-network providers	

NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern.