

CALENDAR-YEAR MAXIMUM (per child)	ANNUAL DEDUCTIBLE (per child)	IN-NETWORK OUT-OF-POCKET MAXIMUM (per child per calendar year)
Unlimited	\$20	\$425

DENTAL PEDIATRIC (through age 18)	In-Network You Pay	Out-of-Network You Pay
CATEGORY A - DIAGNOSTIC AND PREVENTIVE SERVICES		
Exams	0%	25%
Radiographic Images (X-rays)	0%	25%
Prophylaxis (cleaning)	0%	25%
Fluoride Treatment	0%	25%
Sealants	0%	25%
CATEGORY B - MINOR SERVICES		
Fillings	20%	40%
Endodontics (root canals)	20%	40%
Oral Surgery	20%	40%
Extractions	20%	40%
Anesthesia	20%	40%
CATEGORY C - MAJOR SERVICES		
Crowns	50%	70%
Partials and Dentures	50%	70%
Surgical Periodontics	50%	70%



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Important Disclaimer from Arkansas Blue Cross and Blue Shield

This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits and the services that are not covered. If this document conflicts in any way with the policy issued to your employer, the policy shall prevail.