

## Preventive Dental Services Benefit Option

You have purchased this Benefit Option as an additional benefit to your Avera *MyPlan* Health Benefits Policy. This Policy is now amended to include the benefits provided by this Benefit Option.

The effective date for this Benefit Option is stated on the Acceptance Letter that is included with this document.

This Benefit Option is in effect under the same provisions that govern the Avera *MyPlan* Health Benefits Policy. All other terms, provisions and conditions of this Avera *MyPlan* Health Benefits Policy remain unchanged except as stated in this Benefit Option.

If Avera Health Plans chooses to terminate this Benefit Option, you will be provided written notice at least 90 days prior to the termination of this Benefit Option.

### ★ IMPORTANT ★ PLEASE READ ★

#### Preventive Dental Services

- **Covered Services.** This is a Preventive Dental Services Benefit Option only. This Benefit Option does not cover such services as caps, fillings or braces.
- **Network.** You may use a dental provider of your choice when using the benefits provided in this Benefit Option.
- **Reminder.** Please keep this Preventive Dental Services Benefit Option with your Avera *MyPlan* Health Benefits Policy and other important insurance papers.
- **Contact Information**  
Avera Health Plans  
3816 S Elmwood Avenue, Suite 100  
Sioux Falls, SD 57105-6538  
Call 1 (888) 322-2115  
Fax (605) 322-4540  
[www.AveraHealthPlans.com](http://www.AveraHealthPlans.com)

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	Benefit
<p><b>Preventive Dental Office Visits</b></p> <ul style="list-style-type: none"> <li>• <b>Two Visits per Calendar Year</b> (unless stated otherwise)</li> </ul> <p>Services Included:</p> <ul style="list-style-type: none"> <li>- Routine Oral Exam</li> <li>- Teeth Cleaning</li> <li>- Fluoride Application</li> <li>- Bitewings (One set per calendar year; up to four films)</li> <li>- Full Mouth X-Ray (One scan per 36 month period)</li> </ul>	\$25 Co-Pay
<p><b>Sealants</b></p> <ul style="list-style-type: none"> <li>• <b>One Treatment per 36 Month Period</b></li> </ul> <p>Treatments Included:</p> <ul style="list-style-type: none"> <li>- Sealant on the Occlusal Surface of a Permanent Posterior Tooth</li> </ul> <p>Limited to Dependent Children under 16 years of age who are covered under this Benefit Option</p>	\$25 Co-Pay