

**MVP Family Dental (Small Group)
SCHEDULE OF BENEFITS
MVP Health Services Corporation
NY-PPO-SD-002-F**

| COST-SHARING PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost- Sharing | |
|--|--|---|--|
| Deductible <ul style="list-style-type: none"> • One (1) Member under age 19 • Two (2) or more Members under age 19 | <p>None</p> <p>None</p> | <p>None</p> <p>None</p> | |
| Out-of-Pocket Limit <ul style="list-style-type: none"> • One (1) Member under age 19 • Two (2) or more Members under age 19 | <p>\$350</p> <p>\$700</p> | <p>None</p> <p>None</p> | |

| PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT & CARE | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|--|--|--|
| <p>Pediatric Dental Care</p> <ul style="list-style-type: none"> • Emergency Dental Care • Preventive Dental Care • Routine Dental Care • Endodontics • Periodontics • Prosthodontics • Oral Surgery • Orthodontics <p>Orthodontics and major dental (prosthodontics) require Preauthorization</p> | <p>\$25 Copayment</p> <p>\$25 Copayment</p> <p>\$25 Copayment</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> | <p>\$25 Copayment</p> <p>\$25 Copayment</p> <p>\$25 Copayment</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> | <p>One (1) dental exam & cleaning per six (6) month period</p> <p>Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X-rays at six month intervals</p> |

| ADULT DENTAL CARE | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost- Sharing | |
|---|--|---|--|
| Deductible <ul style="list-style-type: none"> • Individual • Family | None None | None None | Deductible Applies to: Routine Dental Care, Endodontics, Periodontics and Prosthodontics. |
| Benefit Specific Deductible <ul style="list-style-type: none"> • Individual | \$ 50 | \$50 | |
| Out-of-Pocket Limit <ul style="list-style-type: none"> • Individual • Family | None None | None None | |
| Annual Maximum on All Services | \$750 Combined Participating and Non-Participating Provider | \$750 Combined Participating and Non-Participating Provider | |

| ADULT DENTAL CARE | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost- Sharing | Limits |
|--|---|---|---------------|
| <ul style="list-style-type: none"> • Emergency Dental Care • Preventive Dental Care • Routine Dental Care • Endodontics • Periodontics • Prosthodontics • Orthodontics <p>Major Dental (prosthodontics) Require Preauthorization</p> | <p>0% Coinsurance</p> <p>0% Coinsurance</p> <p>0% Coinsurance, after Deductible</p> <p>20% Coinsurance, after Deductible</p> <p>20% Coinsurance, after Deductible</p> <p>50% Coinsurance, after Deductible</p> <p>No Coverage</p> | <p>0% Coinsurance</p> <p>0% Coinsurance</p> <p>0% Coinsurance, after Deductible</p> <p>20% Coinsurance, after Deductible</p> <p>20% Coinsurance, after Deductible</p> <p>50% Coinsurance, after Deductible</p> <p>No Coverage</p> | |

