



FROM



# Adult Vision & Dental Benefit

## Adult Vision (Ages 19 years of age and older\*)

	In-Network	Out-of-network
Routine Eye Exam	100% covered	Not Covered
Eyeglasses (frames)	Covered up to \$130	Not Covered
Lenses (per pair) - single, bifocal, trifocal, lenticular	100% covered	Not Covered
Contact lenses (in lieu of glasses)	Covered up to \$130	Not Covered
Contact lens fitting	100% covered	Not Covered
Specialty lens fitting	Covered up to \$50	Not Covered

\*Adult routine vision does not apply to plan maximum.

## Adult Dental\* (Ages 19 years of age and older, does not include Pediatric Dental Coverage)

Annual Maximum Dental Benefit\*\* - \$1,000 per covered person per calendar year (All benefits subject to Annual Maximum.)

### Preventative and Diagnostic (Class 1)

	In-Network	Out-of-network
Routine Cleaning	No charge	Not Covered
Oral Exam	No charge	Not Covered
X-ray - bite-wing, full-mouth and panoramic film	No charge	Not Covered
Topical Fluoride Application	No charge	Not Covered

### Minor Restorative (Class 2)

	In-Network	Out-of-network
Minor Restorative - metal and resin based fillings	50% coinsurance	Not Covered
Endodontic Therapy	50% coinsurance	Not Covered
Periodontics - scaling, root planning and periodontal maintenance	50% coinsurance	Not Covered
Simple Extractions	50% coinsurance	Not Covered
Prosthodontics - relines, rebase, adjustment and repairs	50% coinsurance	Not Covered

### Major Restorative (Class 3)

	In-Network	Out-of-network
Crowns and Bridges	50% coinsurance	Not Covered
Dentures	50% coinsurance	Not Covered
More complex extractions and surgical services	50% coinsurance	Not Covered

\*If you require coverage for Pediatric Dental please shop on the Health Insurance Marketplace for a stand alone dental plan.

\*\*Dental Annual Maximum Benefit does not apply toward any other maximums.

## To learn more about Ambetter contact:

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如果您，或是您正在協助的對象，有關於 Ambetter from Buckeye Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1189 (TTY/TDD 1-877-941-9236)。