

PREMIER DENTAL PLAN

BENEFIT SUMMARY

Deductible and Services	Network Providers	Frequency or Limitation
Calendar Year Deductible	\$50 Per Individual or \$150 Per Family	1 time per calendar year
Preventative/Basic/Major Maximum Benefit	\$1,500	Per family member per calendar year
Orthodontia Maximum Benefit	\$1,000	Lifetime per child 18 & Under
Vision Reimbursement Maximum Benefit	\$200	Per family member per calendar year
Preventative Care	Network Coverage (Deductible Waived)	Frequency or Limitation
Cleaning (Prophylaxis)	100%	2 times per calendar year
Flouride Treatments	100%	1 time per calendar year per child 13 & under
Oral Exams	100%	2 times per calendar year
Sealants (per tooth)	100%	1 time per calendar year per child 13 & under
Bitewings	100%	1 time per calendar year
Full Mouth/Panoramic X-rays	100%	1 time per every 3 years
Basic Care (Subject to Deductible)	Network Coverage (Deductible Applies)	Frequency or Limitation
Space Maintainers	80%	N/A
Restorative Amalgams	80%	N/A
Restorative Composites (anterior & posterior teeth)	80%	N/A
Endodontics	80%	Limited to Non-Surgical Services
Periodontics	80%	Limited to Non-Surgical Services
Denture Repair	80%	N/A
Simple Extractions	80%	N/A

VALUE DENTAL PLAN

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Deductible and Services	Network Providers	Frequency or Limitation
Calendar Year Deductible	\$50 Per Individual or \$150 Per Family	1 time per calendar year
Preventative/Basic/Major Maximum Benefit	\$1,000	Per family member per calendar year
Orthodontia Maximum Benefit	No Coverage Under This Plan	No Coverage Under This Plan
Vision Reimbursement Maximum Benefit	\$200	Per family member per calendar year
Preventative Care	Network Coverage (Deductible Waived)	Frequency or Limitation
Cleaning (Prophylaxis)	100%	2 times per calendar year
Flouride Treatments	100%	1 time per calendar year per child 13 & under
Oral Exams	100%	2 times per calendar year
Sealants (per tooth)	100%	1 time per calendar year per child 13 & under
Bitewings	100%	1 time per calendar year
Full Mouth/Panoramic X-rays	100%	1 time per every 3 years
Basic Care (Subject to Deductible)	Network Coverage (Deductible Applies)	Frequency or Limitation
Space Maintainers	80%	N/A
Restorative Amalgams	80%	N/A
Restorative Composites (anterior & posterior teeth)	80%	N/A
Endodontics	80%	Limited to Non-Surgical Services
Periodontics	80%	Limited to Non-Surgical Services
Denture Repair	80%	N/A
Simple Extractions	80%	N/A

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Major Care (Subject to Deductible)	Network Coverage (Deductible Applies)	Frequency or Limitation
Inlays & Onlays	50%	N/A
Crowns	50%	1 time every 10 years per tooth
Crown Repair	50%	N/A
Endodontics (Surgical)	50%	N/A
Periodontics (Surgical)	50%	N/A
Bridges & Dentures	50%	1 time every 10 years
Complex Extractions	50%	N/A
Anesthesia	50%	N/A

Orhtodontia Care (Subject to Deductible)	Network Coverage	Frequency or Limitation
Orthodontia Services (Braces)	50%	\$1,000 lifetime per child 18 years or under

Vision Care Reimbursement (Deductible Waived)	Network Coverage	Frequency or Limitation
Exams/Frames/Contacts/Lenses/Fittings	100%	\$200 per family member per calendar year

Premier Plan Pricing (Monthlly)

Employee Only	\$67.24
Employee + Spouse	\$131.74
Employee + Children	\$167.06
Family	\$231.23

This summary is not a guarantee of coverage.

Value Dental Plan

Major Care (Subject to Deductible)	Network Coverage (Deductible Applies)	Frequency or Limitation
Inlays & Onlays	50%	N/A
Crowns	50%	1 time every 10 years per tooth
Crown Repair	50%	N/A
Endodontics (Surgical)	50%	N/A
Periodontics (Surgical)	50%	N/A
Bridges & Dentures	50%	1 time every 10 years
Complex Extractions	50%	N/A
Anesthesia	50%	N/A

Orhtodontia Care (Subject to Deductible)	Network Coverage	Frequency or Limitation
Orthodontia Services (Braces)	No Coverage Under This Plan	No Coverage Under This Plan

Vision Care Reimbursement (Deductible Waived)	Network Coverage	Frequency or Limitation
Exams/Frames/Contacts/Lenses/Fittings	100%	\$200 per family member per calendar year

Value Plan Pricing (Monthlly)

Employee Only	\$38.45
Employee + Spouse	\$77.86
Employee + Children	\$88.94
Family	\$128.33