



Your dental coverage

Option 1 or 2: CORE PLAN or BUYUP PLAN plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: CORE PLAN		Option 2: BUYUP PLAN	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Your Bi-weekly premium	\$13.34		\$19.87	
You and Spouse	\$24.15		\$35.96	
You and Child(ren)	\$26.62		\$39.65	
You, Spouse and Child(ren)	\$40.63		\$60.53	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$25	\$50	\$25	\$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	100%	80%	100%	80%
Major Care	0%	0%	60%	50%
Orthodontia	Not Covered (applies to all levels)		50%	50%
Annual Maximum Benefit	\$1000		\$1500	
Maximum Rollover	No		Yes	
Rollover Threshold			\$700	
Rollover Amount			\$350	
Rollover In-network Amount			\$500	
Rollover Account Limit			\$1250	
Lifetime Orthodontia Maximum	Not Applicable		\$1000	
Dependent Age Limits	26		26	



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A Sample of Services Covered by Your Plan:

		Option 1: CORE PLAN		Option 2: BUYUP PLAN	
		<i>Plan pays (on average)</i>		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	No Age Limits		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	100%	80%	100%	80%
	Fillings‡	100%	80%	100%	80%
	Perio Surgery	100%	80%	100%	80%
	Periodontal Maintenance	100%	80%	100%	80%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	100%	80%	100%	80%
	Root Canal	100%	80%	100%	80%
	Scaling & Root Planing (per quadrant)	100%	80%	100%	80%
	Simple Extractions	100%	80%	100%	80%
Surgical Extractions	100%	80%	100%	80%	
Major Care	Bridges and Dentures	0%	0%	60%	50%
	Dental Implants	Not Covered	Not Covered	60%	50%
	Inlays, Onlays, Veneers**	0%	0%	60%	50%
	Single Crowns	0%	0%	60%	50%
Orthodontia	Orthodontia	Not Covered		50%	50%
	Limits:			Adults & Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.