

Summary of Benefits Dental Insurance

Voluntary Dental				
Class Description	<u>HIGH PLAN</u>		<u>LOW PLAN</u>	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Reimbursement	Negotiated Fee Schedule	Schedule Amount	Negotiated Fee Schedule	Schedule Amount
Type A – Preventive	100%	100%	100%	100%
Type B – Basic	80%	80%	80%	80%
Type C – Major	50%	50%	0%	0%
Calendar Year Deductible applies to:	B & C	B & C	B & C	B & C
▪ Individual	\$50	\$50	\$50	\$50
▪ Family	\$150	\$150	\$150	\$150
	Aggregate	Aggregate	Aggregate	Aggregate
Calendar Year Maximum (applies to A,B,C services)	\$1,750	\$1,750	\$1,500	\$1,500
Orthodontia	50%	50%	Not Covered	Not Covered
Orthodontia Lifetime Maximum	\$1,500	\$1,500	Not Covered	Not Covered