

DENTAL BENEFITS

Value, Standard and Royal Plans Benefit Outline—Over 250 Covered Procedures

Deductible—\$50 Calendar Year-Per Person Deductible for Basic and Major Services ONLY!

Elimination Period—12-month waiting period on Major Procedures

Plan Maximum— \$1,000 per Calendar Year-Per Person (This is a combined maximum for dental and eye care.)

* **Dental Rewards** ®—If within a calendar year an individual goes to the dentist at least once and never uses more than \$500 of the plan maximum, the plan maximum will increase an additional \$250 for the next year. This will continue to build up to a maximum total of \$2,000 (\$1,000 annual maximum, plus \$1,000 maximum carryover) as long as the two provisions are met. If the member does not submit a covered claim during the calendar year, they will lose their accumulated carryover benefits and will not earn any for that year. If the member exceeds the \$500 threshold, they will not lose any accumulated carryover, however they will not earn any additional carryover for that year.

Make sure you add up the benefits for each procedure performed to get the total benefit amount for one dental visit!

<u>Insurance Pays 100% of schedule</u> <i>-Sample Schedule of Benefits -</i>	Value	Standard	Royal
Preventive - NO DEDUCTIBLE			
Two evaluations per calendar year	\$13 each	\$16 each	\$20 each
Two cleanings per calendar year—Adult	\$33 each	\$40 each	\$50 each
Two cleanings per calendar year—Child	\$22 each	\$27 each	\$34 each
Fluoride for Children (Under age 19)	\$13	\$15	\$19
Basic			
X-rays—complete series (including bitewings)	\$40	\$48	\$60
Bitewings—two films (Twice in a Benefit Period)	\$15	\$18	\$22
Amalgam restoration (silver fillings)—one surface, primary or permanent	\$35	\$42	\$53
Extraction—Erupted tooth or exposed root (elevation and/or forceps removal)	\$40	\$48	\$60
Surgical removal of tooth (completely bony)	\$83	\$100	\$125
Deep sedation/general anesthesia	\$116	\$140	\$175
Major			
Maxillary partial denture—resin base	\$248	\$300	\$375
Denture repair—Repair Broken Base	\$30	\$36	\$45
Endodontics—root canal, anterior	\$132	\$160	\$200
Periodontal scaling and root planing, four or more teeth. Each quadrant is eligible for consideration once in a 2 year period	\$43	\$52	\$65
Crown—full cast noble metal	\$185	\$224	\$280
Crown repair	\$50	\$60	\$75
Pontics—porcelain fused to noble metal	\$185	\$224	\$280

EYE CARE BENEFITS

-\$0 Deductible

-Benefit - 100% up to a maximum of \$100 and is deducted out of the total \$1,000 maximum allowed for dental benefits

You can go to any licensed vision provider but you will receive extra discounts if you go to an EyeMed provider.

Exams—Includes case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance; tonometry test for glaucoma; gross visual field when indicated; summary finding; prescribing of lenses.

Frames

Lenses—Single; Bifocal; Trifocal; No line bifocal or progressive power; Lenticular

Contact Lenses

-Laser Vision Correction Coverage - If an Insured undergoes or receives a Covered Procedure rendered by a Provider, the policy will pay benefits as stated below. Benefit Amount Payable For Covered Procedures Per Insured Person

Lifetime Maximum Benefit per Eye: For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

<u>1st Benefit Period</u>	<u>2nd Benefit Period</u>
\$0 per eye	\$100 per eye
<u>3rd Benefit Period</u>	<u>4th+ Benefit Period</u>
\$250 per eye	\$500 per eye

For More Information on Benefits

Call 1-877-817-4805 or visit

www.gisconline.com/dental

**For a listing of plan limitations and exclusions visit*

www.gisconline.com/dental or

review your policy certificate once enrolled.



Dental/Eye Care Plan Enrollment Form

To enroll, complete the following form and mail along with your payment to: Greater Insurance Service, PO Box 8633, Madison WI, 53708-8633

(Please Print Clearly)

Name: _____
(FIRST) (M.I.) (LAST)

Home Address: _____
(CITY) (ST) (ZIP)

***Social Security #** _____
*Social Security Number is Needed for your Policy Number

Phone _____

Birthday (mm/dd/yyyy): _____

Requested Effective Date: _____

Plan Enrolling In (check one):
 Value Standard Royal

Coverage Enrolling In (check one):
 Single Only Insured & 1 (Spouse or Child)
 Insured & 2 or More

Do you have any eligible dependents, including a spouse? Yes No

If yes, provide the following information to enroll them. **(Name, Gender (M/F), Birthday)**
Attach Additional Sheets if Necessary

Monthly Dental Premium ... \$ _____

CARE Membership Fee + \$1.00/Month

Total Due Per Month..... = \$ _____

I hereby enroll in the CARE Dental/Eye Care Plan.

_____/_____/_____
Enrollee's Signature *Date*

Agent Signature (If Applicable) *See Reverse Side For Payment Options*