Current Plan Benefits Summaries

CONTRACT TYPE: DENTAL GUARD 2000

This plan is currently offered for Insurance Class 1

PLAN BENEFITS SUMMARY		
	In-Network	**Out-of-Network**
Network	DentalGuard Preferred	None
Coinsurance		
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
Deductible	$50	$50
Waived for preventive?	Yes	Yes
Claim Payment Basis	Fee Schedule	UCR 90%
Maximum	$1,000	$1,000
Orthodontia	Excluded	
Lifetime Maximum	N/A	
Coinsurance	N/A	
Maximum Rollover		
Threshold	$500	
Rollover Amount	$250	
In-network only rollover	$350	
Max Rollover Limit	$1,000	
Dependent Age Limit	26/26	

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.

Additional Dental Information

DENTAL MAXIMUM ROLLOVER SUMMARY		
For Benefit Year Ending: 12/31/2019		
ROLLOVER ACCOUNT SIZE	**NUMBER OF QUALIFYING EMPLOYEES & DEPENDENTS**	**TOTAL ACCOUNT VALUE**
$0	19	$0.00
$1 - $250	0	$0.00
$251 - $500	5	$2,050.00
$501 - $750	1	$700.00
$751 - $1,000	1	$1,000.00
Over $1,000	0	$0.00
TOTAL	**7**	**$3,750.00**

7 of your Employees and Dependents currently are eligible for additional Maximum Rollover amounts.

"Benefit Year" refers to the 12-month period during which charges are counted toward this plan's annual maximum.

"Number of Qualifying Employees and Dependents" reflects information available at the time this renewal package was issued. Additional claims will affect this count.

"Eligibility for additional rollover amounts reflects information available at the time this renewal package was issued. Additional claims will affect the eligibility for additional rollover amounts"

Rollover amounts earned in the benefit year ending 12/31/2019 are applied to the members Maximum Rollover Account for use starting the next benefit year.

Current Plan Benefits Summaries

VSP

VISION

This plan is currently offered for Insurance Class 1

PLAN BENEFITS SUMMARY			
	In-Network	**Out-of-Network**	**Frequency**
Exam Copay	$10	$10	Once per Calendar Year
Exam Allowance	100%	$39	Once per Calendar Year
Materials Copay	$25	$25	
Base Lenses			
Single Vision Allowance	100%	$23	Once per Calendar Year
Bifocal Allowance	100%	$37	Once per Calendar Year
Trifocal Allowance	100%	$49	Once per Calendar Year
Lenticular Allowance	100%	$64	Once per Calendar Year
Contact Lenses			
Elective Allowance	$130	$100	Once per Calendar Year
Therapeutic Allowance	100%	$210	Once per Calendar Year
Frame Retail Allowance	$130	$46	Every Other Calendar Year
Materials Allowance	N/A	N/A	N/A

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.