



# Voluntary Dental Insurance

FOR EMPLOYEES OF GARAGE DOOR REPAIR COMPANY LLC

## ELIGIBILITY - ALL ELIGIBLE EMPLOYEES

<b>Eligibility Requirement</b>	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
<b>Dependent Eligibility Requirement</b>	A child must meet the eligibility requirements of the Policy and be under age 26 if eligible as defined by Policy. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
<b>Premium Payment</b>	The premiums for this insurance are paid in full by you.

## LATE ENTRANT

<b>Type A</b>	None
<b>Type B</b>	12 Months
<b>Type C</b>	12 Months

## CALENDAR YEAR DEDUCTIBLES AND MAXIMUMS

	IN-NETWORK	OUT-NETWORK
<b>Type A</b>	Waived	Waived
<b>Type B &amp; C Deductible</b>		
Individual	\$50	\$50
Family	3 times Individual	3 times Individual
<b>Annual Maximum</b>	\$1,000	\$1,000

The same expenses may be used to satisfy both the In-Network and Out-Network deductible.

## COVERED SERVICES

	IN-NETWORK	OUT-NETWORK
<b>Type A Services</b>	100%	100%
<ul style="list-style-type: none"> <li>• Examinations/Evaluations</li> <li>• Bitewing X-rays</li> <li>• Fluoride Treatments</li> <li>• Cleaning/Prophylaxis</li> <li>• Brush Biopsy/Cancer Screening</li> <li>• Harmful Habit Appliances</li> <li>• Full Mouth X-rays, Panoramic Film</li> </ul>		

COVERED SERVICES	IN-NETWORK	OUT-NETWORK
<b>Type B Services</b> <ul style="list-style-type: none"> <li>• All Other X-Rays</li> <li>• Sealants</li> <li>• Space Maintainers</li> <li>• Palliative Treatment</li> <li>• Periodontal Maintenance</li> <li>• Fillings</li> <li>• Stainless Steel Crowns</li> <li>• Simple Extractions</li> <li>• Oral Surgery</li> <li>• Endodontics</li> <li>• Surgical Extractions</li> <li>• General Anesthesia or I.V. Sedation</li> <li>• Surgical Periodontics</li> <li>• Non-Surgical Periodontics</li> </ul>	80%	80%
<b>Type C Services</b> <ul style="list-style-type: none"> <li>• Full or Partial Removable Dentures</li> <li>• Repair of Full or Partial Removable Dentures</li> <li>• Adjustments, Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures</li> <li>• Bridges</li> <li>• Repair/Recementation of Bridges</li> <li>• Cast Crowns, Inlays, Onlays, Labial Veneers</li> <li>• Repair/Recementation of Cast Crowns/Inlays/Onlays/Labial Veneers</li> <li>• Temporomandibular Joint Disorder - TMD</li> </ul>	50%	50%

The plan pays the percentage shown after the deductible is satisfied up to the maximum. Additional information about the benefits and covered services of this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or benefits administrator if you have questions prior to enrolling.

The plan provides the same coverage levels for both In-Network and Out-Network services. However, because In-Network providers offer their services at predetermined fees, out-of-pocket expenses may be lower for plan members when receiving covered services from an In-Network provider.

The Maximum Allowance for Out-Network Services is based on the 90th Percentile as determined by Mutual of Omaha. Charges that exceed the Maximum Allowance (as defined in the certificate booklet) for any covered dental service are not considered.