Key Access

Dental Plan Rates 2009
For Groups 2-99

	PPO Option 1	
	Existing Dental Coverage*	Groups With No Prior Dental Coverage*
Cost: Single	$18.90	$23.60
Two-Party	$43.40	$54.20
Family	$67.10	$83.90

	PPO Option 2	
	Existing Dental Coverage*	Groups w/ No Prior Dental Coverage*
Cost: Single	$18.90	$23.60
Two-Party	$37.80	$47.20
Family	$56.60	$70.80

* **Groups With No Prior Dental Coverage** are those groups which have not had dental coverage for the past 12 months. (Determined from the termination date of last coverage.)
Existing Dental Coverage groups are those groups which have had, or currently have, dental coverage within the past 12 months.

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Dental Plan Exclusions

EXPENSES NOT COVERED: No benefits will be paid for expenses incurred:

1. for services and supplies not listed in the Summary of Benefits, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
2. for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
3. for services related to, performed in conjunction with, or resulting from a non-covered procedure.
4. for charges in excess of the contracted Fee-for-Service schedule or the Reasonable and Customary rate, whichever applies.
5. for any treatment program which began prior to the date the Insured is covered under the Policy.
6. for crowns, inlays and onlays on teeth that can be restored by direct placement materials.
7. for the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
8. for service or supplies payable under any medical expense, auto or no-fault plan.
9. for any condition covered under any Worker's Compensation Act or similar law.
10. for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
11. for services that are applied toward the satisfaction of a Deductible, if any.
12. for services subject to a waiting period.
13. for charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
14. for hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
15. for drugs or the dispensing of drugs.
16. for oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
17. for implants; myofunctional therapy; athletic mouthguards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.
18. for orthodontia, unless included within the Summary of Benefits.
19. for services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on Our Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits. This exclusion does not apply if the device covers one or more natural teeth lost or extracted while covered under the Plan, or if the prosthetic device was in place when the policy became effective.
20. for composite, resin, or white fillings on posterior primary teeth. Benefit will be reduced to that of an amalgam or silver filling.
21. for the replacement of a filling within 24 months of placement, unless for specific health reasons.
22. for the replacement of retainers.
23. for sealants not applied to permanent bicuspid or molar; applied at age 15 or older; applied 3 years from a previous sealant application; applied to a decayed tooth.
24. for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.
25. during travel or activity outside the United States.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance including, but not limited to, the payment of claims.

The benefits illustrated are in summary form only. They should not be construed as complete in and of themselves. They are only for comparison and in the case of discrepancy the plan documents apply. Please refer to the certificate for a complete description of benefits, limitations, and exclusions.

These plans administered by Dental Select.
5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123, Phone: 801-495-3000, Toll Free: 800-999-9789

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