APP-ATT-D

Dental Coverage

Contract Form No. _______________ Group – Dept. No. ____

The group dental plans are designed around the following categories of dental coverage:

- **Coverage A** **Preventive and Diagnostic Dentistry**
- **Coverage B** **Maintenance and Simple Restorative Dentistry, Oral Surgery, Periodontic and Endodontic Dentistry**
- **Coverage C** **Complex Restorative Dentistry**
- **Coverage D** **Orthodontic Dentistry** ***(optional)***
- **Coverage E** **Temporomandibular Jaw Joint Diagnosis and Treatment** ***(optional)***

Exclusion: Any covered person missing teeth as a result of bridgework prior to the effective date of dental coverage must wait 18 months before obtaining the replacement of teeth.

- Initial Enrollment of the Group .... ☐ Yes ☐ No
- Adding new employees/dependents within 31 days of eligibility.................................... ☐ Yes ☐ No
- Late Enrollees (12-month waiting period)... ☐ Yes ☐ No

Other Waiting Period provisions: ___________________________________

PPO DENTAL PLAN DESIGN			TRADITIONAL DENTAL PLAN DESIGN	
	In-Network	Out-of-Network		
Calendar Year Deductible:			**Calendar Year Deductible:**	
Individual	$ __________	$ __________	Individual	
Coverage A	$ __________	$ __________	Coverage A	$ __________
Coverage B & C	$ __________	$ __________	Coverage B & C	$ __________
Coverage A, B & C	$ __________	$ __________	Coverage A, B & C	$ __________
Coverage D			Coverage D	$ __________
Family Maximum	$ __________	$ __________	Family Maximum	
Coverage A	$ __________	$ __________	Coverage A	$ __________
Coverage B & C	$ __________	$ __________	Coverage B & C	$ __________
Coverage A, B & C	$ __________	$ __________	Coverage A, B & C	$ __________
Coverage D			Coverage D	$ __________
Coinsurance Percentage for:			**Coinsurance Percentage for:**	
Coverage A	________%	________%	Coverage A	________%
Coverage B	________%	________%	Coverage B	________%
Coverage C	________%	________%	Coverage C	________%
Coverage D (Optional)	________%	________%	Coverage D (Optional)	________%
Coverage E (Optional) (Available only with Coverage D)	________%	________%	Coverage E (Optional) (Available only with Coverage D)	________%
Calendar Year Benefit Maximum for Coverages A through C Only:	$ ______________		Calendar Year Benefit Maximum for Coverages A through C Only:	$ ___________
Overall Benefit Maximum for Coverages D & E Only:	$ ______________		Overall Benefit Maximum for Coverages D & E Only:	$ ___________

Other Dental Coverage Provisions:

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