



## Dental and Vision Benefits

Available for Xplorer Premier and Essential (Elite and 1000 plans only)

### Dental and Vision Benefits - Rates effective July 1, 2019

Dental and Vision	Premium per Month	
	Xplorer Premier	Xplorer Essential with Basic U.S. Benefits (Elite and 1000 plans only)
Subscriber only	\$62	\$69
Subs + spouse	\$122	\$135
Subs + children	\$115	\$128
Family	\$205	\$228

Dental Benefits - Deductible not applicable	Worldwide
<b>Annual Max</b>	<b>\$1,500</b>
Diagnostic and Preventative Dental Services	100%
Basic Dental Services	80%
Major Dental Services	50%
Orthodontic Dental Care (Under age 19 only)	50% up to \$1000 Lifetime Max

Vision Benefits - Deductible not applicable	Worldwide
<b>Annual Max</b>	<b>\$250</b>
Vision Examination	70%
Frames or Lenses	70%

### Dental Care

The expenses described in the 3 classes below are reimbursed subject to a yearly maximum indicated in the Benefits Overview Matrix. Please review the entire plan description for complete details.

### Diagnostic and Preventive Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for preventative treatment and necessary diagnostic examinations. **Your Preventive Dental Services are as follows:**

1. Routine oral examinations
2. Emergency oral examinations
3. Prophylaxis (cleaning, scaling, and polishing of teeth)
4. Topical application of fluoride
5. X-rays
6. Space maintainers
7. Sealants
8. Oral pathology laboratory services

## Basic Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for Primary Dental Services. Covered Expenses include:

1. Simple extractions
2. Oral surgery
3. Dentally Necessary injectable drugs administered in a dental office
4. Fillings
5. Non-surgical treatment of periodontal and other diseases of the gums
6. Periodontal scaling and root planing
7. Periodontal maintenance
8. Repair and re-cementing of crowns, inlays, bridgework and dentures
9. Emergency palliative treatment
10. General anesthesia
11. Osseous surgery
12. Endodontic (root canal) treatment
13. X-rays

## Major Services

The Insurer pays the percentage of Covered Expenses shown in the Benefits Overview Matrix for major restorative and prosthodontics (installation) services. Covered Expenses include:

1. Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns
2. Occlusal guards
3. Initial placement of dentures
4. Initial placement of fixed bridgework
5. Replacement dentures and fixed bridgework
6. Relining and rebasing of dentures
7. Tooth build-ups for covered onlays and crowns, including bridge abutments;
8. Precision attachments.

## Orthodontic Services

The Insurer pays the percentage of Covered Expenses indicated in the Schedule of Benefits for necessary orthodontic treatment subject to a specific lifetime maximum also shown in the Schedule. Once this lifetime limit is reached, the Insured Person has no right to any further orthodontic treatment benefits. Orthodontic expenses are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits.

## Vision Care

The Insurer will pay for Covered Expenses per Policy Year as stated in the Schedule of Benefits for routine Vision Care that is not the result of an Injury or Illness. The Deductible is waived. Your coverage includes benefits for vision care when you receive such care from a Physician, Optometrist or Optician. For vision care benefits to be available such care must be Medically Necessary and rendered and billed for by a Physician, Optometrist or Optician, and you must receive such care on or after your Coverage Date.

## Covered Services

Benefits may be provided under this Benefit for the following:

1. One vision and eye health evaluation
2. Prescription plastic or glass lenses
3. Frames
4. Contact Lenses