Voluntary Dental Plan

WV00796 - CONVO COMMUNICATIONS

- ✓ No Employer Contribution / Participation requirement
- ✓ Deluxe & Deluxe Plus plans pay out of network at 80th percentile UCR
- ✓ No billing fees
- ✓ Lifetime Deductibles

CALDENT II VOLUNTARY PLANS						
	Standard[1]	**Deluxe**[2]		**Deluxe Plus**[2]		**Benefits**
Calendar Year Maximum (In and Out of network combined)	**$1,000**	**$1,500**		**$2,000**		
	In or Out of Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**	
Preventive Services	**100%**	**100%**	**80%**	**100%**	**90%**	**Exams** – 2 per calendar year **Cleanings** – 2 per calendar year **Bitewing X-rays** – 1 per calendar year **Emergency Palliative Treatment** **Sealants** to age 16 **Fluoride** – 1 per calendar year to age 16
Preventive Services Lifetime Deductible	**$0**	**$0**	**$50**	**$0**	**$50**	
Basic Services (Includes Endodontics)	**80%**	**80%**	**65%**	**90%** + Includes Perio	**70%** + Includes Perio	**Consultation** **Full Mouth X-rays, Panoramic X-rays** – 1 in 36 months **Periapical X-rays** **Simple Extractions** **Fillings** **Space Maintainers** to age 14 **Endodontics** (Root Canal)
Basic Services Lifetime Deductible	**$50**	**$50**	**$75**	**$50**	**$75**	
Major Services	**50%** +Includes Perio	**50%** +Includes Perio	**40%** +Includes Perio	**60%** +Includes Implants	**40% 1st year 50% thereafter** +Includes Implants	**Bridges** **Dentures** **Crowns** **Inlays, Onlays** **Nightguards** for Bruxism **Oral Surgery**
Major Services Lifetime Deductible	**$50**	**$50**	**$100**	**$50**	**$100**	
VOLUNTARY RATES - MONTHLY						
Employee Only	$33.40	$56.48		$64.79		
Employee + Spouse	$66.79	$112.94		$129.59		
Employee + Child(ren)	$73.59	$118.69		$136.17		
Employee + Family	$101.55	$163.77		$187.97		
VOLUNTARY ORTHODONTIA BENEFITS						
Orthodontic Services Calendar Year Maximum Lifetime Maximum	**Not Covered**	**50%** **$400** **$1,200**		**50%** **$700** **$2,100**		**Straightening of Teeth** Dependent children to age 19
VOLUNTARY ORTHODONTIA RATES - MONTHLY						
Employee Only	**Not Covered**	$56.48		$64.79		
Employee + Spouse	**Not Covered**	$112.94		$129.59		
Employee + Child(ren)	**Not Covered**	$139.59		$172.78		
Employee + Family	**Not Covered**	$184.66		$224.52		

CALDENT II NETWORK	
First Dental Health (PPO Subscriber) http://www.firstdentalhealth.com/	**Foundation for Medical Care** http://kernfmc.com/

- Prior extractions are not covered unless it includes replacement of a natural tooth lost or extracted while covered under this plan. Limitation ends after covered under this policy for 36 consecutive months
- Unmarried dependent children are covered from age 19 until their 26th birthday
- Prosthetic replacement – one time every 5 years
- Periodontics – Scaling 1 per quadrant every 24 months
- Services considered cosmetic will have Alternate Payment Benefits applied: Composite/Resin Fillings on Posterior teeth; all Porcelain Crowns and Bridges

1. Participating and Non Participating Providers paid at the applicable Fee Schedule
2. Participating Providers paid at the applicable fee schedule; Non Participating Providers paid at 80th percentile UCR

THIS FORM IS A SUMMARY OF PLAN BENEFITS ONLY – REFER TO BENEFIT CERTIFICATE FOR COMPLETE BENEFIT DETAILS INCLUDING LIMITATIONS AND EXCLUSIONS

Plan Administered by: **HealthEdge Administrators * P.O. Box 11210 * Bakersfield * CA * 93389**
Underwritten by: **Security Life Insurance Company of America**
Effective 9.1.13

CalVision by HealthEdge Administrators

Eyemed
The Eye Care Plan of America

Voluntary Vision Plan

WV00796 - CONVO COMMUNICATIONS

- ✓ ***NO WAITING PERIODS***
- ✓ 2 Year Rate Guarantee
- ✓ 24 hour access to your benefit information at www.healthedgeinc.com

	SILVER Plan #9751967	GOLD Plan #9751967	PLATINUM Plan #9751967
Eye Examination Frequency	**Once Every 12 Months**	**Once Every 12 Months**	**Once Every 12 Months**
Co-Pay	**$10**	**$10**	**$0**
Eyeglass Frequency	**Once Every 24 Months**	**Once Every 12 Months**	**Once Every 12 Months**
Co-Pay	**$20**	**$10**	**$0**
Frames Frequency	**Once Every 24 Months**	**Once Every 12 Months**	**Once Every 12 Months**
Co-Pay	**$0**	**$0**	**$0**
Contact Lenses	**Instead of Glasses**	**Instead of Glasses**	**Instead of Glasses**
Frequency & Co-Pay	**Same as Glasses**	**Same as Glasses**	**Same as Glasses**
Premium - Monthly			
Employee Only	**$6.81**	**$10.83**	**$13.30**
Employee + 1	**$11.49**	**$18.95**	**$23.48**
Employee + Family	**$16.45**	**$27.54**	**$34.28**

Eye Examination: A routine, complete eye examination, refraction, and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures, which are the responsibility of the member
Eyeglass Lenses: Standard uncoated plastic lenses of any size of power
Frames: Any frame up to a regular retail value of $100. Frames above $100 retail value available at an additional charge.
Contact Lenses: Any pair of contact lenses up to a regular retail price of $100, obtained from a network provider or the mail order program. Contacts above $100 are available at an additional charge
Admin Fee: There will be a $10 per group monthly administration fee for standalone vision. This is waived for CalVision groups that are sold with CalDent.

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When locating a provider select the "Access" network.

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For Effective dates on or after 9.1.13