

# DENTAL-HIGH OPTION

Single - \$39.00  
Couple - \$69.00

**DENTAL COVERAGE** BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

| Plan  | Senior Choice PPO (High)                      |                    |                 |
|---|---|--------------------|-----------------|
|   | Advantage Network                             | Premier Network    | Out-of-Network  |
| <b>Type 1 - Preventive</b><br>Oral Exams, Cleanings, X-Rays | 100%  | 100%               | 100%            |
| <b>Type 2 - Basic</b><br>Fillings                           | 80%   | 80%                | 80%             |
| <b>Type 3 - Major</b><br>Crowns, Bridges, Prosthodontics    | 50%   | 50%                | 50%             |
| <b>Type 4 - Orthodontics</b><br>All Members (Discount)      | Up to 25% Discount                            | Up to 25% Discount | No Coverage     |
| Oral Surgery - (Type 2)                                     | 80%   | 80%                | 80%             |
| Endodontics - (Type 3)                                      | 50%   | 50%                | 50%             |
| Periodontics - (Type 3)                                     | 50%   | 50%                | 50%             |
| <b>Waiting Periods</b>                                      |   |                    |                 |
| Type 1 - Preventive   | None  |                    |                 |
| Type 2 - Basic  | 6 Month Waiting Period                        |                    |                 |
| Type 3 - Major  | 12 Month Waiting Period                       |                    |                 |
| Type 4 - Orthodontics                                       | N/A   |                    |                 |
| <b>Deductible</b>   |   |                    |                 |
| Per Person  | \$25.00                                       | \$50.00            | \$50.00         |
| Family Max  | \$75.00                                       | \$150.00           | \$150.00        |
| Deductible Applies To                                       | Type 2 & Type 3                               | Type 2 & Type 3    | Type 2 & Type 3 |
| Type 3 - Major Annual Maximum Per Person                    | \$750   |                    |                 |
| Annual Maximum Per Person                                   | \$1,500                                       | \$1,000            |                 |
| Orthodontic Lifetime Maximum                                | No Coverage (Eligible for Up to 25% Discount) |                    |                 |
| Specialists   | Paid same as General Dentist                  |                    |                 |
| Reimbursement Schedule                                      | Advantage                                     | Premier            | Premier         |
| <b>Provisions / Limitations / Exclusions</b>                |   |                    |                 |
| Exams (including Periodontal) and Cleanings                 | 2 per year                                    |                    |                 |
| Fluoride  | Not Covered                                   |                    |                 |
| Sealants  | Not Covered                                   |                    |                 |
| Space Maintainers   | Not Covered                                   |                    |                 |
| Vertical Bitewing X-Rays                                    | Up to 4, twice per year                       |                    |                 |
| Periapical X-Rays   | 6 per year                                    |                    |                 |
| Panoramix X-Ray   | 1 every 3 years                               |                    |                 |
| Impacted Teeth  | Covered in Type 2 - Basic                     |                    |                 |
| Anesthesia (For the extraction of impacted teeth only)      | Covered in Type 3 - Major                     |                    |                 |
| Implants  | Not Covered                                   |                    |                 |
| Crowns, Pontics, Abutments, Onlays and Dentures             | 1 every 5 years per tooth                     |                    |                 |
| Fillings on the same surface                                | 1 every 18 months                             |                    |                 |

This policy is renewable or will continue in force at the Subscriber's option, as long as the Subscriber continues to pay all due premiums on a timely basis and meets the eligibility requirements as stated in the Policy. However, EMI Health may change the established premium rate, but only if the rate is changed for all policies of this form number. If the established premium rate changes, EMI Health will notify the Subscriber in writing at least 45 days before such change becomes effective.

All Services are subject to EMI Health Table of Allowances. When using a Non-participating Provider, the insured is responsible for all fees in excess of the Table of Allowances.

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