Dental and Vision Rider

Optional Dental and Vision Rider for Xplorer Elite and Xplorer 1000 plans

Dental and Vision Benefits - Rates effective July 1, 2018

Dental and Vision	Premium per Month
Subscriber only	$60.00
Subs + spouse	$118.00
Subs + children	$111.00
Family	$198.00

Dental Benefits	Worldwide
Annual Max	$1,500
Preventive Dental	100%
Primary Dental	80%
Major Dental	50%
Orthodontic Dental	50% up to $1000 Lifetime Max

Vision Benefits	Worldwide
Annual Max	$250
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. The deductible is waived.

Preventative Dental 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. Oral Examinations
2. Prophylaxis
3. Topical Fluoride Application
4. Dental X-rays
5. Space Maintainers
6. Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

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Primary Dental Services

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

1. Fillings
2. Extractions
3. Oral Surgery
5. Pulp Vitality Tests
6. Apicoectomies
7. Hemisection
8. Biopsies of Oral Tissue
9. Periodontics/Periodontal Therapy
10. Periodontal examination
11. Periodontal maintenance procedures
12. Stainless Steel Crowns
13. Repair of Removable Dentures
14. Recementing of Crowns, Inlays, Onlays and Bridges
15. General Anesthesia/Intravenous Sedation
16. Home Visits

Major Dental 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. Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
2. Fixed Bridgework
3. Bridge Repairs
4. Full and Partial Dentures
5. Denture Adjustments, Rebasing and Relining

Orthodontic Dental Care

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. Vision Examination
2. Single Vision Lenses
3. Bifocal Single Lenses
4. Bifocal Double Lenses
5. Trifocal Lenses
6. Lenticular Lenses
7. Contact Lenses
8. Frames

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