GeoBlue

Dental and Vision Benefits

Available on all Xplorer and Navigator plans

Dental and Vision Benefits

Dental Benefits - Deductible not applicable	
Calendar Year Max	**$1,500**
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	
Calendar Year Max	**$250**
Vision Examination	70%
Frames or Lenses	70%

Dental Care

The expenses described in the three classes below are reimbursed subject to a Calendar Year 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 Preventive Dental Services. Covered Expenses include:

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

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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 - limited to covered person's under the age of 19

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for Major Dental 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 - limited to covered person's under the age of 19

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 Calendar 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 Effective 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