



VILLAGE OF EAST HAMPTON DENTAL/VISION BENEFIT SUMMARY

DENTAL BENEFITS

Calendar Year Deductible	None (for either in or out of network benefits)						
Annual Maximum Benefit	<table border="0" style="margin-left: 20px;"> <tr> <td>Non Contract Employees</td> <td>\$2,200.00 per family per calendar year*</td> </tr> <tr> <td>PBA</td> <td>\$2100.00 per family per calendar year*</td> </tr> <tr> <td>Dispatchers</td> <td>\$2150.00 per family per calendar year*</td> </tr> </table>	Non Contract Employees	\$2,200.00 per family per calendar year*	PBA	\$2100.00 per family per calendar year*	Dispatchers	\$2150.00 per family per calendar year*
Non Contract Employees	\$2,200.00 per family per calendar year*						
PBA	\$2100.00 per family per calendar year*						
Dispatchers	\$2150.00 per family per calendar year*						

**Note: This is a combined Dental Vision Benefit*

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<u>PREVENTATIVE SERVICES</u>		
Cleanings	Covered in Full	100% of R&C
Emergency Treatment CODE 9110	Covered in Full	100% of R&C
Fluoride Treatment – covered for children up to their 18th birthday	Covered in Full	100% of R&C
Oral Examinations	Covered in Full	100% of R&C
Space Maintainers	Covered in Full	100% of R&C
X-rays	Covered in Full	100% of R&C

BASIC SERVICES

Anesthesia	Covered in Full	100% of R&C
Bonding	Covered in Full	100% of R&C
Extractions – Oral Surgery	Covered in Full	100% of R&C
Fillings	Covered in Full	100% of R&C
Gingivectomy	Covered in Full	100% of R&C
Laboratory Tests	Covered in Full	100% of R&C
Periodontic Services	Covered in Full	100% of R&C



VILLAGE OF EAST HAMPTON DENTAL/VISION BENEFIT SUMMARY

DENTAL BENEFITS (CONT.)

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
Root Canals	Covered in Full	100% of R&C
Scaling and Root Planing	Covered in Full	100% of R&C
<u>MAJOR SERVICES</u>		
Porcelain Crowns, Inlays, and Onlays	Covered in Full	100% of R&C
Dentures/Bridgework – Subject to missing tooth clause	Covered in Full	100% of R&C
Gold Crowns, Inlays, and Onlays	Covered in Full	100% of R&C
<u>EXCLUSIONS AND LIMITATIONS</u>		
Sealants	Not Covered	Not Covered
Cleanings	One visit allowed ever 6 months to twice per year	One visit allowed ever 6 months to twice per year
Full Mouth Series & Panoramic X-Rays	Once every three years	Once every three years
Oral Exams	One visit allowed ever 6 months to twice per year	One visit allowed ever 6 months to twice per year
<u>ORTHODONTIC</u>		
Lifetime Maximum of \$1,380.00 per individual. <i>Must start treatment before 19th birthday Invisalign is not covered</i>	Paid as follows: \$300.00 for diagnostic & insertion then \$75.00 per month to the lifetime maximum	

VISION BENEFITS

Vision Benefits	Benefits are paid at 100% of billed charges up to annual maximum
------------------------	--