

SKIDMORE

C O L L E G E

DELTA DENTAL PLANS

Dental Plan A		
Services	In-Network Dentists	Out-of-Network Dentists*
Preventive Services	100% covered by Plan	100% covered by Plan
Basic Services	90% covered by Plan	80% covered by Plan
Major Services	60% covered by Plan	50% covered by Plan
Orthodontics (for children only)	50% covered by Plan	50% covered by Plan
Maximum Benefit Per Person Per Year	\$1,250	\$1,250
Maximum Benefit Per Person Per Lifetime for Orthodontics for children under age 19	\$1,250	\$1,250
Discounted Services	Up To 30%	n/a

Dental Plan B		
Services	In-Network Dentists	Out-of-Network Dentists*
Preventive Services	100% covered by Plan	100% covered by Plan
Basic Services	80% covered by Plan	80% covered by Plan
Major Services	50% covered by Plan	no coverage
Orthodontics	no coverage	no coverage
Maximum Benefit Per Person Per Year	\$1,000	\$1,000
Discounted Services	n/a	n/a

Dental Services are outlined below. However, please review the Dental Plan brochure for a detailed description of coverage.

Preventive Services

Teeth Cleaning
Oral Examinations
Emergency Treatment
X-Rays

Basic Services

Laboratory Tests
Extractions and other Oral Surgery
Fillings: Amalgam, Silicate & Acrylic
Periodontal Services
Root Canal
Repair & Maintenance of Bridgework & Dentures
Anesthesia

Major Services

Gold & Porcelain Fillings & Crowns
Installation of Bridgework & Dentures

- In-Network = Participating Dentists in the Delta Dental Plans;
- *Out-of-Network dental charges will be paid for only up to reasonable and customary charges.
- Basic, Major and Orthodontic coverage are subject to a \$50 per person/\$150 family calendar year deductible;
- Children are eligible for coverage up to age 20, or through age 26 if they are full-time students;
- Discounted Services refers to the set maximum fees that have been negotiated with participating dentists. They average 30% less than the fees usually charged.

Dental Premiums Outlined on Reverse Side

2010 DENTAL PLAN PREMIUMS

Dental Plan A			
Level of Coverage	Employee Premium Per Pay Periods*	Employee Premium Per Month	Employee Annual Premium
Employee Only	\$22.57	\$48.90	\$586.80
Employee & Child(ren)	\$41.14	\$89.14	\$1,069.68
Employee & Spouse	\$44.47	\$96.36	\$1,156.32
Family	\$62.91	\$136.31	\$1,635.72
Dental Plan B			
Level of Coverage	Employee Premium Per Pay Periods*	Employee Premium Per Month	Employee Annual Premium
Employee Only	\$18.51	\$40.11	\$481.32
Employee & Child(ren)	\$33.63	\$72.86	\$874.32
Employee & Spouse	\$36.58	\$79.26	\$951.12
Family	\$51.93	\$112.52	\$1,350.24

*Employee Premium Per Pay Period calculated on 26 pay periods

Dental Plan A COBRA Premiums		
Level of Coverage	Monthly Premium	Annual Premium
Employee Only	\$49.88	\$598.54
Employee & Child(ren)	\$90.92	\$1,091.07
Employee & Spouse	\$98.29	\$1,179.45
Family	\$139.04	\$1,668.43
Dental Plan B COBRA Premiums		
Level of Coverage	Monthly Premium	Annual Premium
Employee Only	\$40.91	\$490.95
Employee & Child(ren)	\$74.32	\$891.81
Employee & Spouse	\$80.85	\$970.14
Family	\$114.77	\$1,377.24