SKIDMORE
COLLEGE

DELTA DENTAL PLANS

Dental Plan A		
SERVICES	**In-Network**	**Out-of- Network***
	Delta Dental PPO Network Dentists	**Non-Delta Dental Dentists**
Preventive Services	100% covered by Plan	100% of reasonable & customary
Basic Services	90% covered by Plan	80% of reasonable & customary
Major Services	60% covered by Plan	50% of reasonable & customary
Orthodontics (for children only)	50% covered by Plan	50% of reasonable & customary
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**	**Out-of- Network***
	Delta Dental PPO Network Dentists	**Non-Delta Dental Dentists**
Preventive Services	100% covered by Plan	100% of reasonable & customary
Basic Services	80% covered by Plan	80% of reasonable & customary
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

*All out-of-network benefits are subject to the deductible and coinsurance, except the Diagnostics, Preventative & Sealants

Dental Services are outlined below. However, please review the Dental Plan brochure and Highlights 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
Implants

- In-Network Participating Dentists refers to the dentists in the Delta Dental PPO 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 26;
- 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

2013 DENTAL PLAN PREMIUMS

Dental Plan A			
Level of Coverage	**Employee Premium Per Pay Periods***	**Employee Premium Per Month**	**Employee Annual Premium**
Employee Only	$21.70	$47.01	$564.12
Employee & Child(ren)	$39.55	$85.70	$1,028.40
Employee & Spouse	$42.76	$92.64	$1,111.68
Family	$60.48	$131.05	$1,572.60
Dental Plan B			
Level of Coverage	**Employee Premium Per Pay Periods***	**Employee Premium Per Month**	**Employee Annual Premium**
Employee Only	$17.80	$38.56	$462.72
Employee & Child(ren)	$32.33	$70.05	$840.60
Employee & Spouse	$35.17	$76.20	$914.40
Family	$49.93	$108.18	$1,298.16

***Employee Premium Per Pay Period calculated on 26 pay periods**

Dental Plan A COBRA Premiums		
Level of Coverage	**Monthly Premium**	**Annual Premium**
Employee Only	$47.95	$575.40
Employee & Child(ren)	$87.41	$1,048.97
Employee & Spouse	$94.49	$1,133.91
Family	$133.67	$1,604.05
Dental Plan B COBRA Premiums		
Level of Coverage	**Monthly Premium**	**Annual Premium**
Employee Only	$39.33	$471.97
Employee & Child(ren)	$71.45	$857.41
Employee & Spouse	$77.72	$932.69
Family	$110.34	$1,324.12