

ST. JOSEPH MERCY OAKLAND – 2009 HIGHLIGHTS

DENTAL PLAN

You have a choice between two dental plan options: the Premier plan and Preferred plan. Shown below is a brief summary of each plan's features, along with your portion of the co-insurance / co-payment responsibility.

DENTAL Plan Highlights	Premier Plan	Preferred Plan	
		In-Network	Out-of-Network
Annual deductible Individual Family	\$50 \$100	N/A	\$25 \$75
Preventive services	100% covered (\$0 associate cost)	100% covered (\$0 associate cost)	100% covered (\$0 associate cost)
Basic services	40%	20%	40%
Major restorative services	50%	40%	50%
Orthodontics (to age 19)	Not covered	50%	50%
Maximums Per person annual (non-orthodontics) Per person lifetime (orthodontics)	\$1,000 Not covered	\$1,500 \$1,500	\$1,500 \$1,000

*Fluoride treatments are covered once every 12 months to age 14.

*Bitewing x-rays are covered once every 12 months.

DISCLAIMER: The information provided in this handout is designed to assist you with understanding your plan options under Trinity Health's Flexible Benefits Program. It is only an overview and it is not intended to be a comprehensive description of your benefit plan design(s). The summary plan descriptions and official plan documents cover these plans in more detail and should be referred to with inquiries on what services are covered by the plan. Whenever there is a discrepancy between printed materials, the official plan documents will prevail.

To view the official summary plan documents, visit <http://mybenefits.trinity-health.org> and click on your Ministry Organization's link.