KANSAS CITY LIFE INSURANCE COMPANY

32dental

Voluntary High Plan

Covered Services *(Pay up to $1,000 Annual Benefit for Certain Procedures)*

Features Include:

- $50 deductible for Basic and Major services; $150 maximum deductible per family
- $1,500 annual maximum
- $1,000 Orthodontic lifetime maximum
- Toll-free Claims Hotline (800) 342-3279

This is not a certificate of insurance. It is a brief description only. The Group Policy alone determines all rights and benefits. Kansas City Life reserves the right to withdraw this offer at any time.

TYPE I
Preventive Services

- **100% coinsurance**
- **$0 individual deductible***
- **$0 family deductible***
- **No benefit waiting period**

- Routine Exams *
- Bitewing X-rays * (Two sets per 12 months (4 x-rays)
- X-rays (One complete series per 36 months)
- Prophylaxis (cleaning)*
- Sealants ** (to age 16)
- Fluoride Treatment *** (to age 16)
- Space Maintainers (to age 14)
- Periodontal Maintenance

* 2 per calendar year
** Any 36 month period
*** 1 per calendar year

TYPE II
Basic Services

- **80% coinsurance**
- **$50 individual deductible***
- **$150 family deductible***
- **No benefit waiting period**

- Restorative (amalgam and composite fillings)
- Oral Surgery (extractions)
- Endodontics (root canal & pulpal therapy)
- Periodontics (treatment of gum diseases, including surgery)
- Emergency Palliative Treatment

TYPE III
Major Services

- **50% coinsurance**
- **$50 individual deductible***
- **$150 family deductible***
- **No benefit waiting period**

- Restorative (inlays & crowns)
- Prosthetics (dentures & bridges)
- Denture and Crown Repair

TYPE IV
Orthodontic

- **50% coinsurance**
- **$0 individual deductible***
- **$0 family deductible***
- **No benefit waiting period**

- Orthodontia (orthodontic care for proper alignment of teeth)
- Orthodontia is provided to dependent children under the age of 19

**Deductible is per calendar year.*

Rates* for
COUNTY OF VICTORIA

$38.04 Employee Only
$100.97 Employee + Family

**rates based on 12 pay periods per year.*

KANSAS CITY LIFE INSURANCE COMPANY — Group Dental Insurance Enrollment Card

Name of Employer: **COUNTY OF VICTORIA** | Group No.: **NV6**

Employee Name: First / Middle / Last | ☐ Female ☐ Male | Social Security Number

Home Address: Street / City / State / Zip | Date of Birth | Marital Status ☐ Single ☐ Married

Date of Employment | Occupation | If COBRA continues please give: Qualifying Event, Date of Event | Work at least 30 hours per week? ☐ Yes ☐ No

Beneficiaries Full Name | Relationship

Check One: ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee and Family

List Name, Sex, and Date of Birth of each Dependent You Wish to Insure.

Name	Sex	Date of Birth	Name	Sex	Date of Birth

Spouse's Dental Carrier: ☐ None

☐ I authorize my employer to deduct from my earnings the amount to cover my share of the contribution for coverage indicated above.

Signature of Employee | Date | Office Use Only

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