



The **Premier** Choice in Dental & Vision Benefits



Freedom Plan

Freedom of Choice of Dentists

EXAMPLE OF SERVICES	AVERAGE COST*	YOUR COST	YOUR SAVINGS
Comprehensive Oral Exam	\$104	No Cost	\$104
Periodic Oral Exam	\$60	No Cost	\$60
Bitewing X-rays (4)	\$76	No Cost	\$76
Panoramic X-ray	\$130	No Cost	\$130
Routine Cleanings	\$106	No Cost	\$106
Filling (One Surface Amalgam)	\$170	\$27	\$143
Molar Root Canal	\$1,200	\$743	\$457
Crown (Porcelain Fused to Noble Metal)	\$1,257	\$86	\$1,171
YOUR TOTAL SAVINGS			\$2,247

INDIVIDUAL RATES	MONTHLY*	ANNUAL
Individual	\$19.88	\$238.56
Individual + Spouse	\$39.76	\$477.12
Individual + Child	\$45.72	\$548.64
Family	\$65.61	\$787.32

GROUP RATES	MONTHLY	ANNUAL
Employee	\$13.97	\$167.64
Employee + Spouse	\$27.95	\$335.40
Employee + Child	\$32.14	\$385.68
Family	\$46.12	\$553.44

*For monthly billing, your account will be debited or charged by the 15th of each month for one month's premium plus a \$1 monthly service charge.

NOTE: A \$35 one-time enrollment fee applies to your first year of enrollment.

*Average cost is based on the national average of the 80th percentile of usual and customary rates as detailed in the National Vision and Dental Advisory Service for 2016.

PLAN BENEFITS

- ◆ Comprehensive and Periodic Oral Exams
- ◆ No Charge for Routine Cleanings: 2 Per Year, 1 Per 6 Months
- ◆ No Charge for Fluoride Application
- ◆ Panoramic/Full-Series Dental X-Rays: Once Every 3 Years
- ◆ Fillings: 2 Per Year Deeply Discounted, for Additional Fillings Higher Co-Pays Apply
- ◆ Surgical Extractions: 2 Per Year Deeply Discounted, for Additional Extractions Higher Co-Pays Apply
- ◆ Crown: 1 Per Year Deeply Discounted, for Additional Crowns Higher Co-Pays Apply
- ◆ Freedom of Choice of Dentists, Allowance Schedule Applies Out-of-Network
- ◆ Lower Out-of-Pocket Costs when using a Network Dentist
- ◆ No Pre-Existing Condition Exclusions
- ◆ No Waiting Periods
- ◆ No Pre-Authorizations
- ◆ No Deductibles
- ◆ No Claim Forms
- ◆ No Calendar Year Maximum
- ◆ Discounts on Specialty Care

ARGUS DENTAL & VISION, INC.

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OUT OF NETWORK ALLOWANCE SCHEDULE

PROCEDURE	OON ALLOWANCE	QUANTITY ALLOWED ANNUALLY
		(INN or ONN)
Exams w D0140	\$40	1
X-Rays	\$20	1
Cleanings	\$35	2
Fillings	\$50	2
Extractions	\$50	2
SRP —1 Quadrant	\$85	1
Crown	\$585	1

Out of Network Annual Max: \$865

