DENTAL HMO – EMPLOYER SPONSORED or VOLUNTARY

DeltaCare® USA			
Plan Type	**HMO**		
Plan Name	Bronze	Silver	Gold
Exam & Diagnostics			
Office Exam	$5	100%	100%
Initial Oral Exam	100%	100%	100%
Periodic Oral Exam	100%	100%	100%
Teeth Cleaning	100%	100%	100%
Bite-Wing X-Ray	100%	100%	100%
Oral Surgery			
Removal of Uncomplicated Single Tooth	$45	$5	100%
Removal of Impacted Tooth-Partially Bony	$65	$75	$70
Removal of Impacted Tooth-Completely Bony	$80	$95	$90
Restorative			
Cavities-Amalgam, 1 Surface	100%	$5	100%
Cavities-Amalgam, 2 Surfaces	100%	$10	100%
Endodontics			
Single Root Canal	$110	$85	$55
Bi-Root Canal	$195	$150	$120
Molar Root Canal	$245	$280	$250
Periodontics			
Gingivectomy-Per Tooth	$50	$80	$80
Periodontal Scaling and Root Planning (quadrant)	$40	$30	$20
Crowns			
Porcelain	$410	$195	$140
Full Cast Noble Metal	$465	$200	$150
Orthodontics			
Children (maximum age 18)	$2,100	$1,700	$1,700
Adult	$2,250	$1,900	$1,900
Prosthetics			
Complete Upper or Lower Denture (each)	$510	$215	$145
Partial Upper or Lower Denture (each)	$535	$180	$120
Waiting Periods	None	None	None

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

ChoiceBuilder®

DENTAL PPO – EMPLOYER SPONSORED or VOLUNTARY

Carrier	Ameritas[4]							
Plan Type	PPO							
Plan Name	Silver		Gold		Platinum		Platinum Plus	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum	$1,100	$1,100	$1,600	$1,600	$2,100	$2,100	$3,000	$2,100
Annual Deductible	$50	$50	$50	$50	$50	$100	$25 (Lifetime)	$25 (Lifetime)
Diagnostic & Preventive Care Preventive Basic Services Major Services Endodontics & Periodontics Restorative	Ded. Waived 100% 80% 50% 50% See EOC	Ded. Applies 80% 80% 50% 50% See EOC	Ded. Waived 100% 80%-90%-100%[1] 50% 80%-90%-100%[1] See EOC	Ded. Applies 100% 80% 50% 80% See EOC	Ded. Waived 100% 75% 75% 75% See EOC	Ded. Waived 100% 75% 75% 75% See EOC	Ded. Waived 100% 80%-90%-100%[1,5] 80% 80%[5] See EOC	Ded. Waived 100% 80% 50% 50% See EOC
Orthodontic Care[3] (optional) Coinsurance Annual Maximum Lifetime Maximum	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $1,000	 50% None $2,000	 50% None $2,000
Waiting Periods Basic Major Ortho	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months	 None None 12 Months
Orthodontic Takeover Credit	**ER Sponsored Only:** At initial group enrollment employer sponsored groups with 5+ eligible employees and prior continuous uninterrupted orthodontic coverage of 12 months, will waive orthodontic waiting period.							
UCR		Average Prevailing Fee[2]		80% of U & C		80% of U & C		80% of U & C
Annual Carry Over Carry Over Amount PPO Bonus Benefit Threshold Maximum Carry Over Amount	 $250 $100 $500 $1,000		 $250 $100 $500 $1,000		 $400 $200 $750 $1,200		 $400 $200 $750 $1,200	
Maximum Carry Over Provision	Dental Rewards® by Ameritas - Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed above, they can increase their next year's coverage by $250 on Silver and Gold Plans or $400 on Platinum and Platinum Plus plans. Plus they can earn an additional $100 on Silver or Gold or $200 on Platinum or Platinum Plus if they visited a network provider. For more information on Dental Rewards please visit www.ameritas.com. (Dental Rewards is a registered service mark of Ameritas Life Insurance Corp. and is used with permission.)							

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

1 Benefit increase by visiting your provider each year (See EOC for details).
2 With the Average Prevailing Fee, the plan allowance for each covered procedure is established according to the median dentist charges in the ZIP Code area where services are provided. Reimbursement allowances automatically adjust if there's an increase or decrease in the overall charges in the area.
3 Child only.
4 Includes Maternity Benefit which provides an additional comprehensive evaluation and cleaning during pregnancy (See EOC for details).
5 Non-Surgical Endodontics & Periodontics is covered at the same cost share as Basic Services.

DENTAL PPO – EMPLOYER SPONSORED or VOLUNTARY

Carrier	Anthem Blue Cross						Delta Dental®[8]					
Plan Type	PPO						PPO					
Plan Name	Silver[7]		Gold – ER Sponsored Only		Platinum – ER Sponsored Only		Silver		Gold- ER Sponsored Only		Platinum- ER Sponsored Only	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network[2]
Annual Maximum	$1,500	$1,500	$2,000	$2,000	$2,500	$2,500	$1,000	$1,000	$1,500	$1,500	$2,000	$2,000
Annual Deductible	$50[4]	$50[4]	$50[4]	$50[4]	$50[4]	$50[4]	$50	$50	$50	$50	$50	$50
Diagnostic & Preventive Care	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived
Preventive	100%	80%	100%	100%	100%	100%	100%	ER SPON: 80% VOLUN: 100%	100%	100%	100%	100%
Basic Services	80%	60%	90%	80%	90%	90%	80%	80%	80%	80%	80%	80%
Major Services	50%	50%	60%	50%	60%	60%	50%	50%	50%	50%	50%	50%
Endodontics & Periodontics	80%[5]	60%[5]	90%[5]	80%[5]	90%[5]	90%[5]	50%	50%	80%	80%	80%	80%
Restorative	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC
Orthodontic Care (optional)												
Coinsurance	Not Covered	Not Covered	50%[6]	50%[6]	50%[6]	50%[6]	50%[1]	50%[1]	50%[1]	50%[1]	50%[1]	50%[1]
Annual Maximum	Not Covered	Not Covered	None	None	None	None	None	None	None	None	None	None
Lifetime Maximum	Not Covered	Not Covered	$2,000[6]	2,000[6]	$2,500[6]	$2,500[6]	$1,000[1]	$1,000[1]	$1,000[1]	$1,000[1]	$1,000[1]	$1,000[1]
Waiting Periods												
Basic	None	None	None	None	None	None	None	None	None	None	None	None
Major	ER SPON: None VOLUN: 12 Months[3]	ER SPON: None VOLUN: 12 Months[3]	None	None	None	None	None	None	None	None	None	None
Ortho	Not Covered	Not Covered	None	None	None	None	None	None	None	None	None	None
Orthodontic Takeover Credit	Does Not Apply		See Plan Specific EOC				Does Not Apply					
UCR		Maximum Allowable Charge		90% of U & C		90% of U & C		Maximum Allowable Charge		Maximum Allowable Charge		See Footnote[2]
Annual Carry Over												
Carry Over Amount	$350		$400		$450		Does Not Apply		Does Not Apply		Does Not Apply	
PPO Bonus	$175		$200		$225							
Benefit Threshold	$700		$800		$900							
Maximum Carry Over Amount	$1,500		$2,000		$2,500							
Maximum Carry Over Provision	Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed above, they can increase their next year's coverage by $350 on Silver, $400 on Gold or $450 on Platinum. Plus they can earn an additional $175 on Silver, $200 on Gold or $225 on Platinum if they only visited network providers.						Does Not Apply					

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

1 Child only.
2 Premier dentists agree to accept their Premier Contracted Fee as payment in full. Non-contracted dentists are reimbursed according to the program allowance, which is the amount determined by a set percentile level of all charges for such services by providers with similar professional standing in the same geographical area.
3 Waiting period waived for initial enrollees covered under the prior group plan.
4 Limit 3x per family.
5 Including Oral Surgery.
6 Covered adults and dependent children.
7 This plan will be unavailable if group adds Orthodontia.
8 Includes Next Stage™ Women's Health benefit enhancements, which provide additional preventative and periodontal services during women's pivotal life stages (See EOC for details).

DENTAL PPO – EMPLOYER SPONSORED or VOLUNTARY

Carrier	MetLife [4]					
Plan Type	PPO					
Plan Name	Silver		Platinum – ER Sponsored Only		Platinum Plus – ER Sponsored Only	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum	$1,250	$750	$2,250	$1,750	$5,000	$2,500
Annual Deductible	$50	$75	$25	$50	None	$50
Diagnostic & Preventive Care	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Waived
Preventive	100%[2]	90%[2]	100%[2]	100%[2]	100%[2]	100%[2]
Basic Services	80%	60%	80%	70%	90%	80%
Major Services	50%	40%	50%	40%	50%	50%
Endodontics & Periodontics	50%	40%	80% / 50%[3]	70% / 40%[3]	90% / 50%[3]	80% / 50%[3]
Restorative	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC
Orthodontic Care[1] (optional)						
Coinsurance	50%	50%	50%	50%	50%	50%
Annual Maximum	None	None	None	None	None	None
Lifetime Maximum	$1,000	$1,000	$1,000	$1,000	$1,500	$1,500
Waiting Periods						
Basic	None	None	None	None	None	None
Major	None	None	None	None	None	None
Ortho	None	None	None	None	None	None
Orthodontic Takeover Credit	Automatic					
UCR		Maximum Allowable Charge		70% of U & C		90% of U & C

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

1 Child only.
2 Benefits paid for Preventive services will not count toward the annual maximum benefit. Only benefits paid for Basic and Major services are applied to the annual benefit maximum. Refer to MetLife plan documents for specific details.
3 Endodontics and Periodontics can be classified as either Basic or Major services depending on the procedure.
4 In-network reimbursement for MetLife plans is based on the negotiated fee, which is the fee that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Out-of-network reimbursement is based on either the negotiated fee (for the Silver plan) or the Usual and Customary (U&C) Fee (for the Platinum and Platinum-Plus plans). The U&C Fee is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.