

# DENTAL HMO – EMPLOYER SPONSORED or VOLUNTARY

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

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# DENTAL PPO – EMPLOYER SPONSORED or VOLUNTARY

Carrier	Ameritas Group						Delta Dental®					
Plan Type	PPO						PPO					
Plan Name	Silver		Gold		Platinum		Silver-Voluntary Only		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 <sup>3</sup>
<b>Annual Maximum</b>	\$1,000	\$1,000	\$1,500	\$1,500	\$2,000	\$2,000	\$1,000	\$1,000	\$1,500	\$1,500	\$2,000	\$2,000
<b>Annual Deductible</b>	\$50	\$50	\$50	\$50	\$50	\$100	\$50	\$50	\$50	\$50	\$50	\$50
Diagnostic & Preventive Care	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived
Preventive	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Basic Services	80%	80%	80%-90%-100% <sup>1</sup>	80%	75%	75%	80%	80%	80%	80%	80%	80%
Major Services	50%	50%	50%	50%	75%	75%	50%	50%	50%	50%	50%	50%
Endodontics & Periodontics	50%	50%	80%-90%-100% <sup>1</sup>	80%	75%	75%	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
<b>Orthodontic Care<sup>4</sup> (optional)</b>												
Coinsurance	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Annual Maximum	None	None	None	None	None	None	None	None	None	None	None	None
Lifetime Maximum	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
<b>Waiting Periods</b>												
Basic	None	None	None	None	None	None	None	None	None	None	None	None
Major	<b>ER SPON:</b> None	<b>ER SPON:</b> None	<b>ER SPON:</b> None	<b>ER SPON:</b> None	<b>ER SPON:</b> None	<b>ER SPON:</b> None	12 Months	12 Months	None	None	None	None
	<b>VOLUN:</b> 6 Months	<b>VOLUN:</b> 6 Months	<b>VOLUN:</b> 6 Months	<b>VOLUN:</b> 6 Months	<b>VOLUN:</b> 6 Months	<b>VOLUN:</b> 6 Months						
Ortho	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	None	None	None	None
<b>Orthodontic Takeover Credit</b>	<b>ER Sponsored Only:</b> At initial group enrollment employer sponsored groups with 10+ eligible employees and prior continuous uninterrupted orthodontic coverage of 12 months, will waive orthodontic waiting period.						Does Not Apply					
<b>UCR</b>		Average Prevailing Fee <sup>2</sup>		80% of U & C		80% of U & C		Maximum Allowable Charge		Maximum Allowable Charge		See Footnote 3

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 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.

4 Child only.

## Dental Rewards® by Ameritas Group

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 half of the annual maximum, they can increase their next year's coverage by \$250 and earn an additional \$100 to \$150 if they visit a network provider. For more information on Dental Rewards®, please visit [www.ameritasgroup.com](http://www.ameritasgroup.com). (Dental Rewards® is a registered service mark of Ameritas Life Insurance Corp. and is used with permission.)

	Silver	Gold	Platinum
Carry Over Amount	\$250	\$250	\$400
PPO Bonus	\$100	\$100	\$200
Benefit Threshold	\$500	\$500	\$750
Maximum Carry Over Amount	\$1,000	\$1,000	\$1,200