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# *2017 Indvididual Dental Plans*

| **Insurance Company** | **Blue Cross Dental** | | **Blue Cross Dental** | |
|---|---|---|---|---|
| **Plan Name** | Blue Cross Dental Direct Basic | | Blue Cross Dental Direct Standard | |
| **Monthly Premium** (Rate for 18-year-old) | $24.36 | | $24.36 | |
| **Monthly Premium** (Rate for 40-year-old) | $16.85 | | $22.48 | |
| **Monthly Premium** (Rate for 60-year-old) | $21.06 | | $28.10 | |
| **Out of Network Coverage** | Yes, same as in-network | | Yes, same as in-network | |
| | **Under 19** | **Over 19** | **Under 19** | **Over 19** |
| **Out of Pocket Maximum** | $350 Individual $700 Family | N/A | $350 Individual $700 Family | N/A |
| **Annual Benefit Maximum** | N/A | $1000 Individual/per person | N/A | $1000 Individual/per person |
| **Deductible** | $75 | N/A | $75 | N/A |
| **Deductible Family** | $75 | N/A | $75 | N/A |
| **Waiting Periods for Certain Services** *see plan summary for specific services | No | No | No | 6-12 months for certain services |
| **Oral Exams** | $0 | $0 | $0 | $0 |
| **Cleanings** | $0 | $0 | $0 | $0 |
| **X-rays** | $0 | $0 | $0 | $0 |
| **Flouride Treatments** | $0 | Not covered | $0 | Not covered |
| **Sealants** | $0 | Not covered | $0 | Not covered |
| **Space Maintainers** | $0 | Not covered | $0 | Not covered |
| **Fillings** | 50% after deductible | 50% | 50% after deductible | 40% |
| **Simple Extractions** | 70% after deductible | Not covered | 70% after deductible | 40% |
| **Minor Treatment for Pain** | 20% | 50% | 20% | 40% |
| **Crowns and Onlays** | 70% after deductible | Not covered | 70% after deductible | Not covered |
| **Root Canal Therapy** | 70% after deductible | Not covered | 70% after deductible | 40% |
| **Periodontal Non surg.** | 70% after deductible | Not covered | 70% after deductible | Not covered |
| **Periodontal surg.** | 70% after deductible | Not covered | 70% after deductible | Not covered |
| **Bridges and Dentures** | 70% after deductible | Not covered | 70% after deductible | Not covered |
| **Single Tooth Implants** | 70% after deductible | Not covered | 70% after deductible | Not covered |
| **Medically Necessary Orthodontia** | 50% after deductible | Not covered | 50% after deductible | Not covered |
| **Elective Orthodontia** | Not covered | Not covered | Not covered | Not covered |
| **Night Guard** | 50% | 50% | 50% | 50% |

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# *2017 Indvididual Dental Plans*

| **Insurance Company** | **Blue Cross Dental** | | **Blue Cross Dental** | |
|---|---|---|---|---|
| **Plan Name** | Blue Cross Dental Direct Plus | | Blue Cross Dental Direct Elite | |
| **Monthly Premium** (Rate for 18-year-old) | $34.89 | | $34.89 | |
| **Monthly Premium** (Rate for 40-year-old) | $34.83 | | $48.27 | |
| **Monthly Premium** (Rate for 60-year-old) | $43.54 | | $60.34 | |
| **Out of Network Coverage** | Yes, same as in-network | | Yes, same as in-network | |
| | **Under 19** | **Over 19** | **Under 19** | **Over 19** |
| **Out of Pocket Maximum** | $350 Individual $700 Family | N/A | $350 Individual $700 Family | N/A |
| **Annual Benefit Maximum** | N/A | $1500 Individual/per person | N/A | $2000 Individual/per person |
| **Deductible** | $25 | N/A | $25 | $50 |
| **Deductible Family** | $25 | N/A | $25 | $50 |
| **Waiting Periods for Certain Services** *see plan summary for specific services | No | 6-12 months for certain services | No | 6-12 months for certain services |
| **Oral Exams** | $0 | $0 | $0 | $0 |
| **Cleanings** | $0 | $0 | $0 | $0 |
| **X-rays** | $0 | $0 | $0 | $0 |
| **Flouride Treatments** | $0 | Not covered | $0 | Not covered |
| **Sealants** | $0 | Not covered | $0 | Not covered |
| **Space Maintainers** | $0 | Not covered | $0 | Not covered |
| **Fillings** | 50% after deductible | 20% | 50% after deductible | 20% after deductible |
| **Simple Extractions** | 50% after deductible | 20% | 50% after deductible | 20% after deductible |
| **Minor Treatment for Pain** | 20% | $0 | 20% | $0 |
| **Crowns and Onlays** | 50% after deductible | 50% | 50% after deductible | 50% after deductible |
| **Root Canal Therapy** | 50% after deductible | 50% | 50% after deductible | 20% after deductible |
| **Periodontal Non surg.** | 50% after deductible | 50% | 50% after deductible | 20% after deductible |
| **Periodontal surg.** | 50% after deductible | 50% | 50% after deductible | 50% after deductible |
| **Bridges and Dentures** | 50% after deductible | 50% | 50% after deductible | 50% after deductible |
| **Single Tooth Implants** | 50% after deductible | 50% | 50% after deductible | 50% after deductible |
| **Medically Necessary Orthodontia** | 50% after deductible | Not covered | 50% after deductible | Not covered |
| **Elective Orthodontia** | Not covered | Not covered | Not covered | Not covered |
| **Night Guard** | 50% | 50% | 50% | 50% |

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# *2017 Indvididual Dental Plans*

| **Insurance Company** | **Delta Dental** | | **Delta Dental** | |
|---|---|---|---|---|
| **Plan Name** | Delta Dental Individual and Family - Starter Plan | | Delta Dental Individual and Family - Value Plan | |
| **Monthly Premium** (Rate for 18-year-old) | $31.62 | | $31.62 | |
| **Monthly Premium** (Rate for 40-year-old) | $24.26 | | $37.37 | |
| **Monthly Premium** (Rate for 60-year-old) | $28.39 | | $47.54 | |
| **Out of Network Coverage** | No, Benefits limited to participating | | No, Benefits limited to participating | |
| | **Under 19** | **Over 19** | **Under 19** | **Over 19** |
| **Out of Pocket Maximum** | $350 Individual $700 Family | N/A | $350 Individual $700 Family | N/A |
| **Annual Benefit Maximum** | N/A | $1000 Individual/per person | N/A | $1000 Individual/per person |
| **Deductible** | Not applicable | Not applicable | Not applicable | Not applicable |
| **Deductible Family** | Not applicable | Not applicable | Not applicable | Not applicable |
| **Waiting Periods for Certain Services** *see plan summary for specific services | No | No | No | 12 months for certain services |
| **Oral Exams** | 0% | 0% | 0% | 0% |
| **Cleanings** | 0% | 0% | 0% | 0% |
| **X-rays** | 0% | 0% | 0% | 0% |
| **Flouride Treatments** | 0% | Not covered | 0% | Not covered |
| **Sealants** | 0% | Not covered | 0% | Not covered |
| **Space Maintainers** | 0% | Not covered | 0% | Not covered |
| **Fillings** | 50% | 50% | 50% | 20% |
| **Simple Extractions** | 50% | 50% | 50% | 20% |
| **Minor Treatment for Pain** | 50% | 50% | 50% | 20% |
| **Crowns and Onlays** | 50% | Not Covered | 50% | 50% |
| **Root Canal Therapy** | 50% | 50% | 50% | 20% |
| **Periodontal Non surg.** | 50% | 50% | 50% | 20% |
| **Periodontal surg.** | 50% | Not covered | 50% | 50% |
| **Bridges and Dentures** | 50% | Not covered | 50% | Not covered |
| **Single Tooth Implants** | 50% | Not covered | 50% | Not covered |
| **Medically Necessary Orthodontia** | 50%; requires prior auth. | Not covered | 50% | Not covered |
| **Elective Orthodontia** | Not covered | Not covered | Not covered | Not covered |
| **Night Guard** | Not covered | 50% | Not covered | 50% |

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# *2017 Indvididual Dental Plans*

| Insurance Company | Delta Dental | | Dentegra | |
|---|---|---|---|---|
| **Plan Name** | Delta Dental Individual and Family - Value Plus Plan | | Dentegra Dental PPO Family Preferred Plan | |
| **Monthly Premium** (Rate for 18-year-old) | $31.62 | | $30.66 | |
| **Monthly Premium** (Rate for 40-year-old) | $46.57 | | $44.27 | |
| **Monthly Premium** (Rate for 60-year-old) | $63.39 | | $44.27 | |
| **Out of Network Coverage** | No, Benefits limited to participating | | Yes, see plan summary | |
| | **Under 19** | **Over 19** | **Under 19** | **Over 19** |
| **Out of Pocket Maximum** | $350 Individual $700 Family | N/A | $350 Individual $700 Family | N/A |
| **Annual Benefit Maximum** | N/A | $1750 Individual/per person | N/A | $1000 Individual/per person |
| **Deductible** | Not applicable | Not applicable | $60 | $60 |
| **Deductible Family** | Not applicable | Not applicable | Not applicable | Not applicable |
| **Waiting Periods for Certain Services** *see plan summary for specific services | No | 12 months for certain services | No | 6-12 months for certain services |
| **Oral Exams** | 0% | 0% | 0% | 0% |
| **Cleanings** | 0% | 0% | 0% | 0% |
| **X-rays** | 0% | 0% | 0% | 0% |
| **Flouride Treatments** | 0% | Not covered | 0% | Not covered |
| **Sealants** | 0% | Not covered | 0% | Not covered |
| **Space Maintainers** | 0% | Not covered | 0% | Not covered |
| **Fillings** | 50% | 20% | 20% after deductible | 20% after deductible |
| **Simple Extractions** | 50% | 20% | 50% after deductible | 50% after deductible |
| **Minor Treatment for Pain** | 50% | 20% | 20% after deductible | 20% after deductible |
| **Crowns and Onlays** | 50% | 50% | 50% after deductible | 50% after deductible |
| **Root Canal Therapy** | 50% | 20% | 50% after deductible | 50% after deductible |
| **Periodontal Non surg.** | 50% | 20% | 20%-50% after deductible | 20%-50% after deductible |
| **Periodontal surg.** | 50% | 50% | 50% after deductible | 50% after deductible |
| **Bridges and Dentures** | 50% | 50% | 50% after deductible | 50% after deductible |
| **Single Tooth Implants** | 50% | 50% | 50% after deductible | 50% after deductible |
| **Medically Necessary Orthodontia** | 50% | Not covered | 50% after deductible | Not covered |
| **Elective Orthodontia** | Not covered | Not covered | Not covered | Not covered |
| **Night Guard** | Not covered | 50% | 50% after deductible | Not covered |