HealthSourceRI FOR EMPLOYERS

2017 SHOP Dental Plans

Insurance Company	**Blue Cross Dental**		**Blue Cross Dental**	
Plan Name	Blue Cross Dental Basic		Blue Cross Dental Standard	
Monthly Premium (Rate for 18-year-old)	$18.52		$18.52	
Monthly Premium (Rate for 40-year-old)	$13.65		$18.14	
Monthly Premium (Rate for 60-year-old)	$21.14		$28.09	
Out of Network Coverage	Yes		Yes	
	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 Individual	$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	No
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 Onlyas	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%

HealthSourceRI FOR EMPLOYERS

2017 SHOP Dental Plans

Insurance Company	**Blue Cross Dental**		**Blue Cross Dental**	
Plan Name	Blue Cross Dental Plus		Blue Cross Dental Elite	
Monthly Premium (Rate for 18-year-old)	$26.52		$26.52	
Monthly Premium (Rate for 40-year-old)	$29.67		$31.31	
Monthly Premium (Rate for 60-year-old)	$45.95		$48.50	
Out of Network Coverage	Yes		Yes	
	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 Individual	$25	N/A	$25	$50
Deductible Family	$25	N/A	$25	$50
Waiting Periods for Certain Services *see plan summary for specific services	No	No	No	No
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 Onlyas	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%

HealthSourceRI FOR EMPLOYERS

2017 SHOP Dental Plans

Insurance Company	Delta Dental		Dentegra	
Plan Name	Delta Dental Premier for Small Businesses - High Plan		Dentegra Dental PPO for Small Businesses Family Preferred Plan	
Monthly Premium (Rate for 18-year-old)	$33.13		$30.66	
Monthly Premium (Rate for 40-year-old)	$28.09		$44.27	
Monthly Premium (Rate for 60-year-old)	$38.68		$44.27	
Out of Network Coverage	Yes		Yes	
	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	$1000 Individual/per person
Deductible Individual	$50 per member applies to certain services	$50 per member applies to certain services	$60	$60
Deductible Family	$50 per member applies to certain services	$50 per member applies to certain services	Not applicable	Not applicable
Waiting Periods for Certain Services *see plan summary for specific services	No	6 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	25% after deductible	25% after deductible	20% after deductible	20% after deductible
Simple Extractions	25% after deductible	25% after deductible	50% after deductible	50% after deductible
Minor Treatment for Pain	25% after deductible	25% after deductible	20% after deductible	20% after deductible
Crowns and Onlyas	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Root Canal Therapy	25% after deductible	25% after deductible	50% after deductible	50% after deductible
Periodontal Non surg.	50% after deductible	50% after deductible	20% - 50% after deductible	20% - 50% after deductible
Periodontal surg.	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Bridges and Dentures	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Single Tooth Implants	50% after deductible	50% after deductible	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	Not covered	Not covered	50% after deductible	Not covered

HealthSourceRI FOR EMPLOYERS

2017 SHOP Dental Plans

Insurance Company	**Guardian**	
Plan Name	Guardian Family Advantage	
Monthly Premium (Rate for 18-year-old)	$30.54	
Monthly Premium (Rate for 40-year-old)	$26.17	
Monthly Premium (Rate for 60-year-old)	$26.17	
Out of Network Coverage	Yes	
	Under 19	**Over 19**
Out of Pocket Maximum	$350 Individual $700 Family	N/A
Annual Benefit Maximum	N/A	$1500 Individual/per person
Deductible Individual	$50	$50
Deductible Family	N/A	N/A
Waiting Periods for Certain Services ***see plan summary for specific services**	No	12 months for certain services
Oral Exams	0%	0%
Cleanings	0%	0%
X-rays	0%	0%
Flouride Treatments	0%	Not covered
Sealants	0%	Not covered
Space Maintainers	0%	Not covered
Fillings	20% after deductible	20% after deductible
Simple Extractions	50% after deductible	50% after deductible
Minor Treatment for Pain	0%	0%
Crowns and Onlyas	50% after deductible	50% after deductible
Root Canal Therapy	50% after deductible	50% after deductible
Periodontal Non surg.	50% after deductible	50% after deductible
Periodontal surg.	50% after deductible	50% after deductible
Bridges and Dentures	50% after deductible	50% after deductible
Single Tooth Implants	50% after deductible	Not covered
Medically Necessary Orthodontia	50%	Not covered
Elective Orthodontia	Not covered	Not covered
Night Guard	50% after deductible	50% after deductible