HealthSourceRI FOR EMPLOYERS

2018 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)	$16.52		$16.52	
Monthly Premium (Rate for 40-year-old)	$12.46		$17.49	
Monthly Premium (Rate for 60-year-old)	$19.29		$27.09	
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	$150	N/A	$150	N/A
Deductible Family	$150	N/A	$150	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	75% after deductible	Not covered	75% after deductible	40%
Minor Treatment for Pain	20%	50%	20%	40%
Crowns and Onlays	75% after deductible	Not covered	75% after deductible	Not covered
Root Canal Therapy	75% after deductible	Not covered	75% after deductible	40%
Periodontal Non surg.	75% after deductible	Not covered	75% after deductible	Not covered
Periodontal surg.	75% after deductible	Not covered	75% after deductible	Not covered
Bridges and Dentures	75% after deductible	Not covered	75% after deductible	Not covered
Single Tooth Implants	75% after deductible	Not covered	75% 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

2018 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)	$26.95		$26.95	
Monthly Premium (Rate for 40-year-old)	$30.61		$32.48	
Monthly Premium (Rate for 60-year-old)	$47.41		$50.30	
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 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%

HealthSourceRI FOR EMPLOYERS

2018 SHOP Dental Plans

Insurance Company	Delta Dental	
Plan Name	Delta Dental Premier for Small Businesses - High Plan	
Monthly Premium (Rate for 18-year-old)	$32.39	
Monthly Premium (Rate for 40-year-old)	$30.25	
Monthly Premium (Rate for 60-year-old)	$41.66	
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 per member applies to certain services	$50 per member applies to certain services
Deductible Family	$50 per member applies to certain services	$50 per member applies to certain services
Waiting Periods for Certain Services *see plan summary for specific services	No	6 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	25% after deductible	25% after deductible
Simple Extractions	25% after deductible	25% after deductible
Minor Treatment for Pain	25% after deductible	25% after deductible
Crowns and Onlays	50% after deductible	50% after deductible
Root Canal Therapy	25% after deductible	25% 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	50% after deductible
Medically Necessary Orthodontia	50%; requires prior auth.	Not covered
Elective Orthodontia	Not covered	Not covered
Night Guard	50% after deductible	Not covered