

FUR EMPLOYERS				
Insurance Company	Blue Cros	ss Dental	Blue Cros	ss Dental
Plan Name	Blue Cross I	Blue Cross Dental Basic Blue Cross Dental		ental Standard
Monthly Premium	\$16.52		\$16.52	
(Rate for 18-year-old)			¥ ·	
Monthly Premium	\$12	2.46	\$17.49	
(Rate for 40-year-old)				
Monthly Premium	\$19.29		\$27.09	
(Rate for 60-year-old)  Out of Network Coverage	Yes		Yes	
Out of Network Coverage	Under 19	Over 19	Under 19	Over 19
	\$350 Individual	Over 19	\$350 Individual	Over 19
Out of Pocket Maximum	\$700 Family	N/A	\$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
	\$0 \$0	Not covered	\$0	Not covered
Space Maintainers	50% after	Not covered	50% after	Not covered
Fillings	deductible	50%	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%



FOR EMPLOYERS				
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%



Plan Name	FOR EMPLOYERS				
Monthly Premium (Rate for 18-year-old)   \$32.39   \$30.25	Insurance Company	Delta Dental			
Rate for 18-year-old)   Monthly Premium (Rate for 40-year-old)   Monthly Premium (Rate for 60-year-old)   \$41.66	Plan Name				
Rate for 40-year-old)   Monthly Premium (Rate for 60-year-old)   \$41.66     Out of Network Coverage	_	\$32.39			
Monthly Premium (Rate for 60-year-old)	•	\$30.25			
Out of Pocket Maximum         Under 19         Over 19           Annual Benefit Maximum         N/A         \$350 Individual \$700 Family         N/A           Deductible Individual         \$50 per member applies to certain services to certain services         \$50 per member applies to certain services         \$50 per member applies to certain services           Waiting Periods for Certain Services         No         6 months for certain services           *see plan summary for specific services         \$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         deductible           Geductible         25% after deductible         deductible           Winor Treatment for Pain         25% after deductible         deductible           Crowns and Onlays         50% after deductible         deductible           Root Canal Therapy         25% after deductible         deductible           Periodontal Non surg.         50% after deductible         deductible           Bridges and Dentures         50% after deductible	Monthly Premium	\$41.66			
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         No         6 months for certain services           Waiting Periods for Certain Services         No         6 months for certain services           Waiting Periods for Certain Services         \$0         \$0           Vaiting Periods for Certain Services         No         6 months for certain services            Vaiting Periods for Certain Services         \$0         \$0           Vaiting Periods for Certain Services         \$0         \$0      <		Yes			
Annual Benefit Maximum    \$700 Family   \$1500		Under 19	Over 19		
Deductible Individual	Out of Pocket Maximum	•	N/A		
Deductible Individual   per member applies to certain services   \$50   \$50   per member applies to certain services   \$50   per tain services   \$50   per member app	Annual Benefit Maximum		· ·		
Deductible Family         per member applies to certain services         per member applies to certain services           Waiting Periods for Certain Services         No         6 months for certain services           See plan summary for specific services         \$0         \$0           Cleanings         \$0         \$0           X-rays         \$0         Not covered           Sealants         \$0         Not covered           Space Maintainers         \$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         25% after deductible         25% after deductible           Root Canal Therapy         25% after deductible         25% after deductible           Deriodontal Non surg.         50% after deductible         50% after deductible           Bridges and Dentures         50% after deductible         50% after deductible           Bridges and Dentures         50% after deductible         50% after deductible           Medically Necessary Orthodontia         50%; requires prior auth.	Deductible Individual	per member applies to certain services	per member applies to certain services		
Services  *see plan summary for specific services  Oral Exams  Oral Exams  \$0 \$0  Cleanings  \$0 \$0  X-rays  Flouride Treatments  Sealants  So Not covered  Sealants  So Not covered  Space Maintainers  Fillings  Simple Extractions  Minor Treatment for Pain  Crowns and Onlays  Root Canal Therapy  Periodontal Non surg.  Periodontal surg.  Bridges and Dentures  Single Tooth Implants  Minot Curerd  Not covered  So Not covered  25% after deductible deductible  25% after deductible deductible  25% after deductible  30% after deductible  50% after deductible  Single Tooth Implants  Medically Necessary  Orthodontia  Not covered  Not covered  Not covered  Not covered	Deductible Family	per member applies	per member applies		
Cleanings \$0 \$0  X-rays \$0 \$0  Flouride Treatments \$0 Not covered  Sealants \$0 Not covered  Sealants \$0 Not covered  Space Maintainers \$0 Not covered  Fillings 25% after deductible deductible  Simple Extractions 25% after deductible deductible  Crowns and Onlays 25% after deductible deductible  Crowns and Onlays 50% after deductible deductible  Root Canal Therapy 25% after deductible deductible  Periodontal Non surg. 50% after deductible deductible  Periodontal Surg. 50% after deductible deductible  Bridges and Dentures 50% after deductible deductible  Single Tooth Implants 50%; requires prior auth.  Not covered Not covered Not covered Not covered Surgers 100 Not covered Not covere	Services	No			
Scalants   \$0   \$0   \$0   \$0   \$0   \$0   \$0   \$		\$0	\$0		
Stands   S	Cleanings		· · · · · · · · · · · · · · · · · · ·		
Flouride Treatments  Sealants  \$0  Not covered  Space Maintainers  \$0  Not covered  Space Maintainers  \$0  Not covered  \$1  \$25% after deductible  \$25% after de			\$0		
Fillings  Fillings  Simple Extractions  Minor Treatment for Pain  Crowns and Onlays  Root Canal Therapy  Periodontal Non surg.  Periodontal surg.  Bridges and Dentures  Single Tooth Implants  Medically Necessary Orthodontia  Fillings  25% after deductible  50% after deductible deductible deductible  50% after deductible Not covered Not covered	Flouride Treatments	\$0	Not covered		
Fillings  Simple Extractions  Minor Treatment for Pain  Crowns and Onlays  Root Canal Therapy  Periodontal Non surg.  Periodontal surg.  Bridges and Dentures  Single Tooth Implants  Medically Necessary Orthodontia  Fillings  25% after deductible deductible  50% after deductible deductible  Som after deductible	Sealants	\$0	Not covered		
Simple Extractions    Simple Extractions	Space Maintainers	\$0	Not covered		
Minor Treatment for Pain  Crowns and Onlays  Root Canal Therapy  Periodontal Non surg.  Periodontal surg.  Bridges and Dentures  Single Tooth Implants  Medically Necessary Orthodontia  Minor Treatment for Pain  25% after deductible  50% after deductible  25% after deductible  50% after deductible  Not covered  Not covered	Fillings				
Minor Treatment for Pain  Crowns and Onlays  Root Canal Therapy  Periodontal Non surg.  Periodontal surg.  Bridges and Dentures  Single Tooth Implants  Medically Necessary Orthodontia  Plant Cuard  Might Guard  Dentures  Dentu	Simple Extractions		deductible		
Root Canal Therapy   25% after deductible   50% after deductible	Minor Treatment for Pain		deductible		
Periodontal Non surg.  Periodontal Surg.  Periodontal surg.  Periodontal surg.  Bridges and Dentures  Single Tooth Implants  Medically Necessary Orthodontia  Elective Orthodontia  Periodontal Surg.  Solvafter deductible deductible  50% after deductible  Not covered  Not covered  Not covered	Crowns and Onlays		deductible		
Periodontal Non surg.  Periodontal surg.  Bridges and Dentures  Single Tooth Implants  Medically Necessary Orthodontia  Elective Orthodontia  Description:  Medically Necessary Orthodontia  Not covered	Root Canal Therapy	deductible	deductible		
Bridges and Dentures  Single Tooth Implants  Medically Necessary Orthodontia  Elective Orthodontia  Diagram deductible Not covered Not co	Periodontal Non surg.	deductible	deductible		
Bridges and Dentures  deductible  50% after deductible  Medically Necessary Orthodontia  Elective Orthodontia  Not covered	Periodontal surg.	deductible	deductible		
Single Tooth Implants   deductible   deductible	Bridges and Dentures	deductible	deductible		
Orthodontia prior auth.  Elective Orthodontia Not covered Not covered  Night Guard Not covered Not covered	Single Tooth Implants				
Night Guard 50% after Not covered	_	•	Not covered		
Night Guard Not covered	Elective Orthodontia		Not covered		
deductible	Night Guard	50% atter	Not covered		