2017 Dental Selection Form: **Delta Dental of New York**

	Delta Dental PPO℠ Plans				Integrated Small Business Dental Program (PPO)				Pediatric Plan
					Adults & Dependents Age 19+			Pediatric Benefit for Children Under Age 19	
	BASIC OPTION	ESSENTIAL OPTION	TRADITIONAL OPTION	COMPREHENSIVE OPTION	High Option	Mid Option	Low Option		DELTA DENTAL PPO PEDIATRIC BASIC PLAN
Diagnostic	100%	100%	100%	100%	100%	100%	100%	100%	100%
Preventive	100%	100%	100%	100%	100%	100%	100%	100%	100%
Basic Restorative	50%	50%	80%	80%	80%	50%	50%	50%	50%
Oral Surgery	0%	50%	80%	80%	80%	50%	0%	50%	50%
Endodontics	0%	50%	80%	80%	80%	50%	0%	50%	50%
Periodontics	0%	50%	80%	80%	80%	50%	0%	50%	50%
Major Restorative	0%	50%	50%	50%	50%	50%	0%	50%	50%
Prosthodontics	0%	50%	50%	50%	50%	50%	0%	50%	50%
Implants	0%	50%	50%	50%	N/A	N/A	N/A	N/A	0%
TMJ (temporomandibular joint)	50%	50%	50%	50%	50%	50%	0%	50%	50%
Orthodontics	0%	0%	0%	50%	0%	0%	0%	50%*	50%*
Annual Maximum	$1,500	$1,500	$1,500**	$2,000**	$1,500	$1,500	$1,500	N/A	N/A
Ortho Maximum	N/A	N/A	N/A	$1,000	N/A	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum per Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$350 for Delta Dental PPO providers/No maximum for Delta Dental Premier® or non-Delta Dental providers***	$350 for Delta Dental PPO providers/ No maximum for Delta Dental Premier® or non-Delta Dental providers***
Out-of-Pocket Maximum per 2+ Individuals	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$700 for Delta Dental PPO providers/No maximum for Delta Dental Premier® or non-Delta Dental providers***	$700 for Delta Dental PPO providers/ No maximum for Delta Dental Premier® or non-Delta Dental providers***
Deductible/Individual	$25	$50	$25	$50	$25	$50	$25	$65	$65
Deductible/Family	$75	$150	$75	$150	$75	$150	$75	$195	$195
Deductible waived for Diagnostic and Preventive	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Annual Maximum waived for Diagnostic and Preventive	No	No	Yes	Yes	No	No	No	N/A	N/A

* Orthodontic services are covered for medical necessity only. A 12-month waiting period applies.

**Diagnostic and preventive services do not contribute to the annual maximum.

***After the annual out-of-pocket maximum has been fulfilled, applicable services are covered at 100% .

Note: Percentages are based on Delta Dental's applicable maximum plan allowance or dentist's actual fee, whichever is less.

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Rates apply to groups headquartered in the CDPHP 24-county service area. Monthly plan rates are valid for effective dates: January 1, 2017 through December 1, 2017.

Important notes regarding Pediatric Plan :

Small Groups Only — In accordance with the essential pediatric dental coverage requirement outlined in the Affordable Care Act, any employee (and applicable dependents) that enroll in a business plan will be automatically enrolled in the Pediatric Plan. Rates will be billed for each family member who is 18 years old or younger.

MONTHLY RATES

	Commercial Delta Dental PPO℠ Plans								Integrated Small Business Dental Program (PPO)			Pediatric Plan*
	BASIC OPTION		ESSENTIAL OPTION		TRADITIONAL OPTION		COMPREHENSIVE OPTION		Adults & Dependents Age 19+ with Pediatric Benefit for Children Under Age 19			DELTA DENTAL PPO PEDIATRIC BASIC PLAN
									HIGH OPTION	MID OPTION	LOW OPTION	
NETWORK	**PPO**	**PPO+ PREMIER**	**PPO**	**PPO+ PREMIER**	**PPO**	**PPO+ PREMIER**	**PPO**	**PPO+ PREMIER**				**PPO**
Albany Area Monthly Rate per Individual < 19	N/A								N/A			$16.09
Mid-Hudson Area Monthly Rate per Individual < 19												$18.00
Syracuse Area Monthly Rate per Individual < 19												$15.82
Utica/Watertown Area Monthly Rate per Individuals < 19												$15.73
Employee Only	$13.51	$18.86	$26.26	$34.33	$34.15	$44.66	$33.71	$41.61	$29.18	$23.28	$14.41	N/A
Employee & Spouse	$29.59	$41.29	$55.95	$73.11	$72.31	$94.50	$71.80	$88.64	$58.36	$46.56	$28.83	
Employee & Child(ren)	$35.16	$43.10	$49.99	$65.33	$69.10	$90.30	$70.36	$85.96	$50.37	$44.47	$35.61	
Employee & Family	$50.72	$62.18	$81.39	$106.37	$110.04	$143.82	$114.03	$139.06	$98.62	$86.82	$69.09	
SELECT YOUR PLAN									SELECT YOUR PLAN			
CHOOSE YOUR PLAN *Please review all options and select ONE from this row*	24000003 Plan C ◯	24000004 Plan D ◯	24000006 Plan F ◯	24000007 Plan G ◯	24000010 Plan J ◯	24000011 Plan K ◯	24000012 Plan L ◯	24000013 Plan M ◯	24000078 High ◯	24000079 Mid ◯	24000080 Low ◯	Plan 70 ◯

Please Check One: ◯ Voluntary or ◯ Contributory	Previous Group Dental Insurance: ◯ Yes ◯ No – Waiting period applies	
Group Name	Group Number	Effective Date
Broker	Tax ID Number	

The Company agrees to execute a group contract with the same Effective Date and dental plan selection within 90 days hereof.

Employer Signature	Print Name	Date

CDPHN receives variable compensation from Delta Dental of New York, Inc., based in whole or in part on types of contracts and volume sold. You may contact CDPHN directly to obtain information about this compensation.

*Rates for the pediatric plan are capped at three individuals.