

DELTA DENTAL INSURANCE COMPANY PRESENTS

Program Y-2: Small Group Program - Groups With Prior Dental Coverage

FOR THE EMPLOYEES OF

Prospect Name

BENEFITS (Based on Provider Fee Schedule – PPO fee in and out of network)

. Diagnostic & Preventive Services:		100%
. Restorative & Denture Repairs:	80/20	
. Basic Services:		80/20
Simple extractions covered under basic	80/20	
 <i>Major Services:</i>		
. Endodontics:		50/50*
. Oral Surgery:		50/50*
. Periodontics:		50/50*
. Crowns & Prosthodontics:		50/50*
. Orthodontics:		50/50*#

* 12 month waiting period Major Services and Orthodontic Services for all enrollees not covered under the employer's prior dental plan, and all new hires.

Orthodontic benefit year maximum of \$350 (not to exceed \$1,000 lifetime maximum)
Orthodontics for dependent children to age 19 only. Delta shall receive credit for any amounts paid under the employer's prior plan for Orthodontic Benefits.

Deductible (Annual Aggregate):

\$50 per member per year
\$150 family maximum per year

Deductible not applied to Diagnostic & Preventive Services.

Maximum Benefit Amount (Each Year):

For each Eligible Person: \$1,000 (including orthodontic benefit)

Note: Teeth extracted prior to the effective date are NOT covered benefits unless extracted while the enrollee was covered under the employer's prior dental plan.

Rates and benefits levels are based on group having prior dental coverage.

Monthly Rates:

	<u>Employee</u>	<u>Family</u>	
Two Year Contract	\$	\$	
	<u>Employee</u>	<u>Employee & One</u>	<u>Employee & Two or More</u>
Two Year Contract	\$	\$	\$

Delta Dentals proposed premiums are based on an enrollment of at least 5 primary enrollees.

Section 125 required. Coverage may not be dropped or changed other than during an Open Enrollment Period or because of a qualifying status change.

PROOF OF PRIOR DENTAL COVERAGE REQUIRED

Agent: