2019 BLUESHIELD OF NORTHEASTERN NEW YORK - Small Businesses

1 Essential benefits to ensure members receive complete oral health coverage through BlueShield's own dental network.
2 Flexibility to see out-of-network dentists. Out-of-network services are reimbursed at 100% of the in-network schedule. No balance billing by the non-participating provider.
3 One card for both medical and dental coverage.

Plan Name	Tier	Rate Per Month	Deductible (Embedded)	Out of Pocket Maximum	Diagnostic & Preventive (Xrays, Cleaning, Exam)	Basic Restorative (Fillings, extractions, perdiodontics, endodontics)	Major Restorative Prosthodontics, Crowns, Dentures)	Orthodontics (Medically necessary, routine braces not covered)	Orthodonic Lifetime Maximum	Annual Maximum
Blue Value Dental 3 PPO	**Individual Employee/Spouse Parent/Child(ren) Family**	**$30.07 $60.14 $68.62 $112.13**	$50 per member / $150 family maximum per plan year	N/A	$0 Copayment	20% Coinsurance after deductible	50% Coinsurance after deductible	50% coinsurance (adult and pediatric cosmetic orthodontics), subject to lifetime max	$1,000 per member per lifetime (Pediatric and adult cosmetic, routine braces)	$1,500 per member per plan year

Can be purchased separately from BlueShield medical.

2019 BLUESHIELD OF NORTHEASTERN NEW YORK - BLUE PEDIATRIC DENTAL PPO

1 Essential benefits to ensure members receive complete oral health coverage through BlueShield's own dental network.
2 Flexibility to see out-of-network dentists. Out-of-network services are reimbursed at 100% of the in-network schedule. No balance billing by the non-participating provider.
3 One card for both medical and dental coverage.

Plan Name	Tier	Rate Per Month	Deductible (Embedded)	Out of Pocket Maximum	Diagnostic & Preventive (Xrays, Cleaning, Exam)	Basic Restorative (Fillings, extractions, perdiodontics, endodontics)	Major Dental (bridges, crowns, dentures)	Orthodontics (Medically necessary, routine braces not covered)	Orthodonic Lifetime Maximum	Annual Maximum
Blue Pediatric Dental PPO	**PER CHILD**	**$20.67**	N/A	$350 one child; $700 two or more children. (Per Plan Year)	$20 Copay	50% Coinsurance	50% Coinsurance	50% Coinsurance (medically necessary only; routine braces not covered), subject to out of pocket max.	N/A	N/A

PEDIATRIC COVERAGE TO AGE 19 YEARS

2019	CDPHP DELTA DENTAL PPO+ PREMIERE Plan K - Small Business ONLY							
CARRIER	**Tier**	**Rate Per Month**	**Deductibles**	**Diagnostic, Preventive**	**Basic Restorative, Oral Surgery, Endodontics, Periodontics**	**Major Restorative Prosthodontics, Implants, TMJ**	**Orthodontics**	**Annual Maximum**
CDPHP DELTA DENTAL PPO PREMIERE Plan K	**Individual** **Employee/Spouse** **Parent/Child(ren)** **Family**	**$45.55** **$96.39** **$92.11** **$146.70**	$25 per person; $75 per family	100% Covered. (Not counted toward annual maximum)	80% Covered	50% Covered	0	$1,500 Diagnostic or preventive services do not count toward annual maximum.)
	PEDIATRIC DENTAL COVERAGE TO AGE 19: $16.46 per child (aged 18 and under; up to 3) will be added to the premium shown for Parent/Child(ren) or Family rates.							
CDPHP Pediatric Basic Dental Plan 70	**Individual** (up to 3 children per family)	**$16.46**	$65 per person	100% Covered	50% Covered	50% Covered	50% covered for medical necessity only. 12-month waiting period.	Waived for D/P

2019	GUARDIAN DENTAL - Small Business or Individual (Sole Proprietor)									
CARRIER	**Tier**	**Rate Per Month**		**Preventive Care**	**Restoration & Oral Surgery: IN NETWORK**	**Restoration & Oral Surgery: OUT OF NETWORK**	**Endodontics & Periodontics: IN NETWORK**	**Endodontics & Periodontics**	**Orthodontics**	**Maximum Benefit**
GUARDIAN DENTAL PPO Z1 Class 2	**Individual** **Employee/Spouse** **Parent/Child(ren)** **Family**	**$38.90** **$92.44** **$101.88** **$156.35**		100% covered	100% coverage after $50 deductible per covered person	80% coverage after $50 deductible per covered person	60% coverage after $50 deductible per covered person (6-month Waiting Period)	50% coverage after $50 deductible per covered person (6-month Waiting Period)	Not available.	$1,000 max per covered person per calendar year
	FOR PLAN YEAR 2019, RATES REMAIN THE SAME AS PLAN YEAR 2018.									

2019	THE STANDARD	Dental Insurance Plan	**** NO NEW ENROLLMENT BEING ACCEPTED BY CARRIER ****							
CARRIER	Tier	*Per Month:* Albany-Colonie Chamber	*Per Month:* Chamber of Schenectady County	Per Year Benefits	Participation Requirements	Enrollment Level	Maximum Benefit	Preventive Care	BASIC 1 *	BASIC II **	MAJOR ***
THE STANDARD	**Individual**	**$52.11**	**$64.60**	**YEAR 1**	No Restrictions	No Restrictions	$1,000 max per covered person per calendar year ^	**100%**	50% coverage after $50 deductible	25% coverage after $50 deductible	Not Available
	Employee/Spouse	**$101.59**	**$125.95**								
	Parent/Child(ren)	**$99.00**	**$121.43**								
	Family	**$148.48**	**$182.78**								
	* X-Rays (Intra-oral), Fillings, Sealants. ** Endodontics, Minor Periodontics, Simple Extractions, Minor Restorations.			**YEAR 2**	No Restrictions	No Restrictions	$1,000 max per covered person per calendar year	**100%**	80% coverage after $50 deductible	50% coverage after $50 deductible	25% coverage after $50 deductible
	*** Periodontic surgery, Complex Oral Surgery, Major Restoration Prosthodontics (fixed & removed)			**YEAR 3**	No Restrictions	No Restrictions	$1,000 max per covered person per covered year	**100%**	80% coverage after $50 deductible	80% coverage after $50 deductible	50% coverage after $50 deductible

RATES FOR 2018 REMAIN IN EFFECT THROUGH 2019.