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Dental Plan Options - Plan Year 2022

	ManhattanLife Since 1850			aetna℠					moda HEALTH			PacificSource HEALTH PLANS			Spirit DENTAL & VISION				Ameritas			Willamette Dental Group
Plan Name	Dental, Vision, Hearing			Dental, Vision, Hearing					PPO	Exclusive PPO	PPO Bright Smiles	Dental Advantage		Kids Dental Advantage	3500	1200/2500/5000	1200	750/1000/1250	PrimeStar Value	PrimeStar Access	PrimeStar Total	TrueCare
Network (click to search)	No Network			No Network					Delta Dental PPO			Advantage			Ameritas				Ameritas			Willamette Dental
Plan Brochure (click to view)	Brochure			Brochure					Brochure			Brochure			Brochure				Brochure	Brochure	Brochure	Brochure
Annual Benefit Maximum (age 19+)	$1,000	$1,500	$3,000	$1,000	$1,500	$2,000	$2,500	$3,000	$1,000	$1,500	None	$1,000	$1,500	None	$3,500	1200/2500/5000	$1,200	750/1000/1250	$750	$1000/$2000	$2000/$2500	None
Deductible	$100/person			$100/person					$0			$0			$100/person - Lifetime				$0 on Preventive, $50 all other			None
Preventive (In-Network)	Year 1: 60% Year 2: 70% Year 3+: 80%			100%					Under 19: 100% Adults: 75%	100%	100%	100%			100%				Year 1: 90% Year 2: 100%	100%	100%	$0 - $35
Basic (In-Network)	Year 1: 60% Year 2: 70% Year 3+: 80%			Year 1: 65% Year 2+: 80%					Under 19: 25% Adults: 60%	70%	25%	80%			Year 1: 65% Year 2: 80% Year 3+: 90%	Year 1: 50% Year 2: 60% Year 3+: 80%	Year 1: 50% Year 2: 65% Year 3+: 80%	Year 1: 50% Year 2: 60% Year 3+:70%	Year 1: 50% Year 2: 80%	Year 1: 65% Year 2+: 80%	Year 1: 80% Year 2+: 90%	$45 - $80
Major (In-Network)	Year 1: 0% Year 2: 70% Year 3+: 80%			Year 1: 20% Year 2+: 50% Implants: $1,500 lifetime maximum					Under 19: 25% Adults: 50%	50%	25%	50%			Year 1: 10% Year 2: 50% Year 3+: 65%	Year 1: 25% Year 2: 30% Year 3+: 50%	Year 1: 25% Year 2: 50% Year 3+: 50%	Year 1: 20% Year 2: 30% Year 3+: 40%	Year 1: 0% Year 2+ 15%	Year 1: 20% Year 2+: 50%	Year 1: 20% Year 2+: 50%	Under 19: $100 - $350 Adults: $100 - $600
Orthodontia	Not Covered			Year 1: 0% Year 2+ 50% ($1,500 lifetime max)					Under 19: 25% Adults: N/A	Under 19: 50% Adults: N/A	25%	Not Covered			Year 1: 10%, Year 2: 25%, Year 3: 50% $1,200 Lifetime maximum			Not Covered	Not Covered	Under age 19 $1,000 lifetime max Year 1: 15% Year 2: 50%	Not Covered	$2,800 copay
Out of Pocket Pediatric Maximum (ages 0-18)	N/A			N/A					$350/child, $700/family (In-network only)			$375/child, $750/family (In-network only)			N/A				N/A			None
Deductible (Out of Network)	Same as in-network Plan payments based on Usual, Customary and Reasonable charges			Same as in-network					$0	Not Covered		$50/person, $150/family			Network Plan pays based on contracted fees (Maximum Allowable Charges, MAB) Choice Plan pays based on 90th percentile of Usual, Customary, and Reasonable charges.				Covered at the same co-insurance as In-Network but based on maximum allowable benefit.	$0/$50	Covered at the same co-insurance as In-Network but based on maximum allowable benefit.	Not Covered Out of area emergency treatment is reimbursed up to $100 minus applicable copayments.
Preventive (Out of Network)									50% No balance billing for Delta Dental Premier only			80%								80%		
Basic (Out of Network)												80% after deductible								Year 1: 45% Year 2: 60%		
Major (Out of Network)												50% after deductible								Year 1: 10% Year 2: 30%		
Waiting Period (ages 19+) Preventive Services	None			None for dental Vision covered after 6 months Hearing covered after 12 months					None			None			None				None	None		None
Waiting Period: (ages 19+) Basic Services	None								6 months		None	6 months*		None					None			None
Waiting Period: (ages 19+) Major Services	12 months								12 months		None	12 months*		None					12 months			12 months
Important Notes, **PLEASE READ**	This is a reimbursement policy. Children can only enroll as dependents. See brochure for family rates. Additional discounts if you use a dentist in the Careington Maximum Care PPO network.			Vision covered at 65% Year 1, 80% Year 2+ Inclues eye exams, glasses and contact lenses. Hearing covered 80% up to $500 Year 2+ Inclues hearing exams and aids.					**You can only enroll during open enrollment or if you have a qualifying event.** Waiting periods may be waived with proof of prior dental coverage. See brochure for full details.			*Waiting periods may be waived with proof of prior dental coverage.			Spirit $3,500 also covers hearing exams and hearing aids. It covers $75 per year for hearing exams and 50% of hearing aids cost up to the max benefits. Max hearing aid benefit per year: Year 1: $200 Year 2: $300 Year 3: $400				Preventive procedures are not deducted from plan's annual maximum benefit. Teeth whitening is included as a Major Benefit on the PrimeStar Plan. Annual hearing exam benefit paid up to $75 for PrimeStar Total. Primestar total hearing aid benefit per ear: Year 1: $200, Year 2: $300, Year 3: $400			See brochure for fee schedule
Age	**Manhattan Life**			**Aetna**					**Moda**	**Moda**	**Moda (Kids)**	**PacificSource**		**PacificSource (Kids)**	**Spirit**				**Ameritas PrimeStar**			**Willamette**
0 - 17	N/A	N/A	N/A	N/A					$36	$40	$36	$41	$41	$39	N/A				N/A			$46.77
18	$30.25	$40	$48.17	$67.54	$72.08	$75.66	$78.41	$80.53							Network Plan Indiv $56.76 Family $180.29 Choice Plan Indiv $89.90 Family $286.31	Network Plan Indiv $49.72 Family $168.03 Choice Plan Indiv $79.68 Family $263.91	Network Plan Indiv $39.42 Family $135.08 Choice Plan Indiv $59.72 Family $200.02	Network Plan Indiv $31.39 Family $100.46 Choice Plan Indiv $47.72 Family $152.70	Individual $25.43 Individual + child $50.86 Family $81.38	Individual $45.51 Indiv + child $93.05 Family $154.17	Individual $57 Indiv + child $113.68 Family $181.02	
19 - 24									$27	$29	N/A	$46		N/A								$50.96
25 - 29												$43	$48									
30 - 34									$29	$31		$47	$53									$56.49
35 - 39									$32	$35		$51	$57									
40 - 44	$32.75	$42.33	$52.25						$33	$36		$56	$62									$66.18
45 - 49									$34	$37		$60	$67									
50 - 54									$37	$40		$61	$69									
55 - 59	$35.08	$46.00	$59.58						$42	$44		$64	$72									$78.11
60 - 64									$45	$48												
65 - 74	$37.58	$49.67	$64.42						$47	$50		$67	$76									
75 - 85	$43.17	$57.08	$74.08												Waive the $25 application fee with code $MILE20							
	Enroll Direct			Call us to Enroll					Enroll Direct			Enroll Direct			Enroll Direct				Enroll Direct			Enroll Direct

This sheet is a simplified plan comparison. Refer to plan summaries for complete plan benefits. Please note that percentages shows are what the plan pays.