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Network (click to search)	No Network	No Network	Delta Dental PPO				Delta Dental Premier	PPQ			Ameritas					Ameritas								
Plan Brochure (click to view)	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	\$1,000	\$1,500	None	\$1,000/\$1500	\$1,200	\$1500/\$3500	\$1200/\$2500/\$5000	\$1000/\$2000	\$1500/\$2500	750/\$1500	\$1500/\$2000	\$2500/\$3000						
Deductible	\$100/person	\$100/person	\$0				\$50/\$150	\$0			\$100/person - Lifetime					\$0 on Preventive, \$50 all other								
Preventive (In-Network)	Year 1: 60% Year 2: 70% Year 3+: 80%	100%	Under 19: 100% Adults: 75%	100%	100%	100%	100%			100%					100%									
Basic (In-Network)	Year 1: 60% Year 2: 70% Year 3+: 80%	Year 1: 65% Year 2+: 80%	Under 19: 25% Adults: 60%	70%	75%	80%	80%			50%	Year 1: 50% Year 2: 65% Year 3+: 80%	Year 1: 65% Year 2+: 100%	Year 1: 50% Year 2: 60% Year 3+: 80%	Year 1: 50% Year 2: 70% Year 3: 80%	Year 1: 50% Year 2: 80%	Year 1: 65% Year 2+: 80%	Year 1: 80% Year 2+: 90%							
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%	50%			20%	Year 1: 25% Year 2+: 50%	Year 1: 20% Year 2+: 50%	Year 1: 25% Year 2: 30% Year 3+: 60%	Year 1: 15% Year 2: 40% Year 3+: 50%	Year 1: 20% Year 2: 40% Year 3+: 50%	Year 1: 10% Year 2+ 20%	Year 1: 20% Year 2+: 50%	Year 1: 20% Year 2+: 50%						
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	Not Covered			Not covered	Under age 19 \$1,200 lifetime max Year 1: 10% Year 2: 25% Year 3: 50%	Not covered	Under age 19 \$1,200 lifetime max Year 1: 10% Year 2: 25% Year 3: 50%	Not covered	Not Covered	Under age 19 \$1,000 lifetime max Year 1: 15% Year 2: 50%	Not Covered							
Out of Pocket Pediatric Maximum (ages 0-18)	N/A	N/A	\$450/child, \$900/family (In-network only)				N/A	\$450/child, \$900/family (In-network only)			N/A					N/A								
Deductible (Out of Network)	Same as in-network  Plan payments based on Usual, Customary and Reasonable charges.	Same as in-network	\$0	50% No balance billing for Delta Dental Premier only	Not Covered	\$0	\$50/person, \$150/family			PPO Plans pay based on contracted fees (Maximum Allowable Charges, MAB)					Based on contracted fee (MAC), so will pay what to 8 out of 10 dentists pay in the area			\$0/\$50	\$0/\$50	\$0/\$50				
Preventive (Out of Network)			70%			80%	90%																	
Basic (Out of Network)			Year 1: 25% Year 2: 40%			Year 1: 45% Year 2: 60%	Year 1: 70% Year 2: 80%																	
Major (Out of Network)			Year 1: 5% Year 2: 10%			Year 1: 10% Year 2: 30%	Year 1: 15% Year 2: 40%																	
Waiting Period (ages 19+) Preventive Services	None	None for dental Vision covered after 6 months Hearing covered after 12 months	None				None			None					None									
Waiting Period: (ages 19+) Basic Services	None		6 months *	None	6 months all ages*	6 months*	None																	
Waiting Period: (ages 19+) Major Services	12 months		12 months*	None	12 months all ages*	12 months*	None																	
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+ Includes eye exams, glasses and contact lenses.  Hearing covered 80% up to \$500 Year 2+ Includes hearing exams and aids.	*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.			Preferred PPO 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  Implants covered on all plans except Flex Plans					Preventive procedures are not deducted from plan's annual maximum benefit.  Teeth whitening is included as a Major Benefit on the PrimeStar Boost Plan.  Annual hearing exam benefit paid up to \$75 for PrimeStar Complete.  Primestar total hearing aid benefit per ear: Year 1: \$200, Year 2: \$300, Year 3: \$400									
Age	Manhattan Life			Aetna					Moda		Moda (Kids)	PacificSource		PacificSource (Kids)	Spirit						Ameritas PrimeStar			
0 - 17	N/A	N/A	N/A	N/A					\$41	\$46	\$41	\$42	\$44	\$44	\$44	N/A						N/A		
18	\$37.58	\$49.43	\$59.52	\$57.05	\$58.32	\$59.32	\$60.10	\$60.68	\$28	\$34	N/A	\$39	\$40	\$48	Individual \$25.31	Individual \$37.07	Individual \$48.65	Individual \$49.49	Individual \$47.52	Individual \$66.33	Individual \$28.17	Individual \$53.05	Individual \$62.18	
19 - 24				\$33	\$36	\$42	\$46	\$55																
25 - 29				\$33	\$39	\$46	\$50	\$59																
30 - 34				\$34	\$40	\$47	\$55	\$65																
35 - 39	\$40.47	\$52.42	\$64.57	Age 26-50: \$59.5	Age 25-50: \$63.46	Age 26-50: \$66.59	Age 25-50: \$69	Age 26-50: \$70.84	\$35	\$41	\$48	\$59	\$70	Indiv + 1 \$50.63	Inviv + 1 \$76.62	Indiv +1 \$97.01	Indiv + 1 \$101.45	Indiv + 1 \$95.03	Indiv + 1 \$132.68	Family \$90.12	Family \$180.50	Family \$197.62		
40 - 44				\$38	\$44	\$52	\$60	\$72																
45 - 49				\$41	\$48	\$57	\$63	\$75																
50 - 54				\$45	\$52	\$62	\$66	\$78																
55 - 59	\$43.46	\$56.95	\$73.63	\$67.54	\$72.08	\$75.66	\$78.41	\$80.53	\$48	\$55	\$66	\$78	Family \$81.01	Family \$129.07	Family \$154.35	Family \$168.81	Family \$152.05	Family \$21.28	Waive the \$25 application fee with code SMILE20					
60 - 64				Age 71+: \$69.61	Age 71+: \$74.85	Age 71+: \$78.73	Age 71+: \$81.73	Age 71+: \$84.02																
65 - 74				\$46.44	\$61.48	\$79.60	\$48	\$55	\$66	\$78														
75 - 85				\$53.45	\$70.64	\$91.55	\$69.51	\$74.85	\$78.73	\$81.73	\$84.02													
Updated 10/20/2025	Enroll Direct			Call us to Enroll					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.