DENTAL HMO – EMPLOYER SPONSORED or VOLUNTARY

DeltaCare® USA			
Plan Type	**HMO**		
Plan Name	Bronze	Silver	Gold
Exam & Diagnostics			
Office Exam	$5	100%	100%
Initial Oral Exam	100%	100%	100%
Periodic Oral Exam	100%	100%	100%
Teeth Cleaning	100%	100%	100%
Bite-Wing X-Ray	100%	100%	100%
Oral Surgery			
Removal of Uncomplicated Single Tooth	$45	$5	100%
Removal of Impacted Tooth-Partially Bony	$65	$75	$70
Removal of Impacted Tooth-Completely Bony	$80	$95	$90
Restorative			
Cavities-Amalgam, 1 Surface	100%	$5	100%
Cavities-Amalgam, 2 Surfaces	100%	$10	100%
Endodontics			
Single Root Canal	$110	$85	$55
Bi-Root Canal	$195	$150	$120
Molar Root Canal	$245	$280	$250
Periodontics			
Gingivectomy-Per Tooth	$50	$80	$80
Periodontal Scaling and Root Planning (quadrant)	$40	$30	$20
Crowns			
Porcelain	$410	$195	$140
Full Cast Noble Metal	$465	$200	$150
Orthodontics			
Children (maximum age 18)	$2,100	$1,700	$1,700
Adult	$2,250	$1,900	$1,900
Prosthetics			
Complete Upper or Lower Denture (each)	$510	$215	$145
Partial Upper or Lower Denture (each)	$535	$180	$120
Waiting Periods	None	None	None

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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ChoiceBuilder®

DENTAL PPO – EMPLOYER SPONSORED or VOLUNTARY

Carrier	Ameritas[8]						Anthem Blue Cross					
Plan Type	PPO						PPO					
Plan Name	Silver		Gold		Platinum		Silver		Gold – ER Sponsored Only		Platinum – ER Sponsored Only	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum	$1,100	$1,100	$1,600	$1,600	$2,100	$2,100	$1,500	$1,500	$2,000	$2,000	$2,500	$2,500
Annual Deductible	$50	$50	$50	$50	$50	$100	$50[4]	$50[4]	$50[4]	$50[4]	$50[4]	$50[4]
Diagnostic & Preventive Care	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived
Preventive	100%	80%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%
Basic Services	80%	80%	80%-90%-100%[1]	80%	75%	75%	80%	60%	90%	80%	90%	90%
Major Services	50%	50%	50%	50%	75%	75%	50%	50%	60%	50%	60%	60%
Endodontics & Periodontics	50%	50%	80%-90%-100%[1]	80%	75%	75%	80%[5]	60%[5]	90%[5]	80%[5]	90%[5]	90%[5]
Restorative	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC
Orthodontic Care (optional)												
Coinsurance	50%[3]	50%[3]	50%[3]	50%[3]	50%[3]	50%[3]	Not Covered	Not Covered	50%[6]	50%[6]	50%[6]	50%[6]
Annual Maximum	None	None	None	None	None	None	Not Covered	Not Covered	None	None	None	None
Lifetime Maximum	$1,000[3]	$1,000[3]	$1,000[3]	$1,000[3]	$1,000[3]	$1,000[3]	Not Covered	Not Covered	$2,000[6]	$2,000[6]	$2,500[6]	$2,500[6]
Waiting Periods												
Basic	None	None	None	None	None	None	None	None	None	None	None	None
Major	None	None	None	None	None	None	ER SPON: None VOLUN: 12 Months[7]	ER SPON: None VOLUN: 12 Months[7]	None	None	None	None
Ortho	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	Not Covered	Not Covered	None	None	None	None
Orthodontic Takeover Credit	**ER Sponsored Only:** At initial group enrollment employer sponsored groups with 10+ eligible employees and prior continuous uninterrupted orthodontic coverage of 12 months, will waive orthodontic waiting period.						Does Not Apply		See Plan Specific EOC			
UCR		Average Prevailing Fee[2]		80% of U & C		80% of U & C		Maximum Allowable Charge		90% of U & C		90% of U & C
Annual Carry Over												
Carry Over Amount	$250		$250		$400		$350		$400		$450	
PPO Bonus	$100		$100		$200		$175		$200		$225	
Benefit Threshold	$500		$500		$750		$700		$800		$900	
Maximum Carry Over Amount	$1,000		$1,000		$1,200		$1,500		$2,000		$2,500	
Maximum Carry Over Provision	Dental Rewards® by Ameritas - Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed above, they can increase their next year's coverage by $250 on Silver and Gold Plans or $400 on Platinum. Plus they can earn an additional $100 on Silver or Gold or $200 on Platinum if they visited a network provider. For more information on Dental Rewards please visit www.ameritas.com. (Dental Rewards is a registered service mark of Ameritas Life Insurance Corp. and is used with permission.)						Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed above, they can increase their next year's coverage by $350 on Silver, $400 on Gold or $450 on Platinum. Plus they can earn an additional $175 on Silver, $200 on Gold or $225 on Platinum if they only visited network providers.					

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

1 Benefit increase by visiting your provider each year (See EOC for details).

2 With the Average Prevailing Fee, the plan allowance for each covered procedure is established according to the median dentist charges in the ZIP Code area where services are provided. Reimbursement allowances automatically adjust if there's an increase or decrease in the overall charges in the area.

3 Child only.

4 Limit 3x per family.

5 Including Oral Surgery.

6 Covered adults and dependent children.

7. Waiting period waived for initial enrollees covered under the prior group plan.

8. Includes Maternity Benefit which provides an additional comprehensive evaluation and cleaning during pregnancy (See EOC for details).

DENTAL PPO – EMPLOYER SPONSORED or VOLUNTARY

Carrier	Delta Dental®						MetLife [4]					
Plan Type	PPO						PPO					
Plan Name	Silver		Gold- ER Sponsored Only		Platinum- ER Sponsored Only		Silver		Platinum – ER Sponsored Only		Platinum Plus – ER Sponsored Only	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network[2]	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum	$1,000	$1,000	$1,500	$1,500	$2,000	$2,000	$1,250	$750	$2,250	$1,750	$2,500	$2,000
Annual Deductible	$50	$50	$50	$50	$50	$50	$50	$75	$25	$50	None	$50
Diagnostic & Preventive Care	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Waived
Preventive	100%	ER SPON: 80% VOLUN: 100%	100%	100%	100%	100%	100%[5]	90%[5]	100%[5]	100%[5]	100%[5]	100%[5]
Basic Services	80%	80%	80%	80%	80%	80%	80%	60%	80%	70%	90%	80%
Major Services	50%	50%	50%	50%	50%	50%	50%	40%	50%	40%	50%	50%
Endodontics & Periodontics	50%	50%	80%	80%	80%	80%	50%	40%	80% / 50%[3]	70% / 40%[3]	90% / 50%[3]	80% / 50%[3]
Restorative	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC	See EOC
Orthodontic Care[1] (optional)												
Coinsurance	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Annual Maximum	None	None	None	None	None	None	None	None	None	None	None	None
Lifetime Maximum	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,500	$1,500
Waiting Periods												
Basic	None	None	None	None	None	None	None	None	None	None	None	None
Major	ER SPON: None VOLUN: 12 Months	ER SPON: None VOLUN: 12 Months	None	None	None	None	None	None	None	None	None	None
Ortho	ER SPON: None VOLUN: 12 Months	ER SPON: None VOLUN: 12 Months	None	None	None	None	None	None	None	None	None	None
Orthodontic Takeover Credit	Does Not Apply						Does Not Apply					
UCR		Maximum Allowable Charge		Maximum Allowable Charge		See Footnote[2]		Maximum Allowable Charge		70% of U & C		90% of U & C

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

1 Child only.

2 Premier dentists agree to accept their Premier Contracted Fee as payment in full. Non-contracted dentists are reimbursed according to the program allowance, which is the amount determined by a set percentile level of all charges for such services by providers with similar professional standing in the same geographical area.

3. Endodontics and Periodontics can be classified as either Basic or Major services depending on the procedure.

4. In-network reimbursement for MetLife plans is based on the negotiated fee, which is the fee that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Out-of-network reimbursement is based on either the negotiated fee (for the Silver plan) or the Usual and Customary (U&C) Fee (for the Platinum and Platinum-Plus plans). The U&C Fee is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

5. Benefits paid for Preventive services will not count toward the annual maximum benefit. Only benefits paid for Basic and Major services are applied to the annual benefit maximum. Refer to MetLife plan documents for specific details.

VISION – EMPLOYER SPONSORED or VOLUNTARY

Carrier	EyeMed (Provided by Ameritas)					
Plan Name	Silver		Gold		Platinum	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Eye Examination	$10 Copay	Up to $25	$10 Copay	Up to $25	100%	Up to $25
Frames	$100 Allowance, 20% off balance over $100	Up to $40	$130 Allowance, 20% off balance over $130	Up to $40	$150 Allowance, 20% off balance over $150	Up to $40
Standard Lenses						
Single Vision	$15 Copay	Up to $20	$10 Copay	Up to $20	100%	Up to $20
Lined Bifocal	$15 Copay	Up to $35	$10 Copay	Up to $35	100%	Up to $35
Lined Trifocal	$15 Copay	Up to $60	$10 Copay	Up to $60	100%	Up to $60
Standard Progressive	$65 Copay[5]	Not Covered	$65 Copay[5]	Not Covered	$65 Copay[5]	Not Covered
Contact Lenses (in lieu of lenses & frames)	$100 Allowance, 15% off balance over $100	Up to $65	$130 Allowance, 15% off balance over $130	Up to $65	$150 Allowance, 15% off balance over $150	Up to $65
Benefit Frequency*	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12	12/12/12

Carrier	VSP® Vision Care[2,3,4,6]					
Plan Name	Silver ER Sponsored Only		Gold		Platinum	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Eye Examination	$20[1] Copay	Up to $45	$10 Copay	Up to $45	$10 Copay	Up to $45
Frames	$180 Allowance	Up to $70	$180 Allowance	Up to $70	$180 Allowance	Up to $70
Standard Lenses						
Single Vision	Covered In Full	Up to $30	$25 Copay	Up to $30	$25 Copay	Up to $30
Lined Bifocal	Covered In Full	Up to $50	$25 Copay	Up to $50	$25 Copay	Up to $50
Lined Trifocal	Covered In Full	Up to $65	$25 Copay	Up to $65	$25 Copay	Up to $65
Standard Progressive	Covered In Full	Up to $50	Covered In Full	Up to $50	Covered In Full	Up to $50
Contact Lenses (in lieu of lenses & frames)	$150 Allowance	Up to $105	$150 Allowance	Up to $105	$150 Allowance	Up to $105
Benefit Frequency*	12/24/24	12/24/24	12/12/24	12/12/24	12/12/12	12/12/12

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* Benefit Frequency - Exams/lenses/frames
1 The $20 Copay applies to exam and/or materials once in an eligibility period
2 Average 20%-25% savings on non-covered lens enhancements.
3 20% off additional glasses and sunglasses, including lens options, from any VSP Vision Care doctor within 12 months of your last WellVision Exam
4 Includes $250 per eye laser surgery benefit (in-network)
5 Premium Progressive in-network are discounted.
6 Sun Care included- provides Plano Sunglasses to members who do not have a prescription.

CHIROPRACTIC/ACUPUNCTURE – EMPLOYER SPONSORED or VOLUNTARY

Chiropractic (Provided by Landmark Healthplan)[3]

New Patient Evaluation & Management	Initial evaluation, problem-focused Initial evaluation, expanded Initial evaluation (history and examination), detailed Home visit, new patient, problem-focused	$65[1] per visit
Established Patient Re-Examination & Management	Re-examination Re-examination, expanded Home visit, established patient, problem-focused	$50[2] per visit
Modalities	Hot or cold packs, supervised Mechanical traction, supervised Unattended electrical stimulation, supervised Whirlpool, supervised Diathermy (microwave), supervised Infrared, supervised Attended electrical stimulation, constant attendance Iontophoresis, constant attendance Contrast baths, constant attendance Ultrasound, constant attendance (phonophoresis)	$50[2] per visit
Therapeutic Procedures	Physical medicine; treatment to one area, therapeutic exercise Manual therapy techniques (myofascial release, trigger point therapy, or manual traction)	$50[2] per visit
Chiropractic Manipulative Treatment	Spinal, one to two regions Spinal, three to four regions Spinal, five regions Extraspinal, one or more regions	$50[2] per visit
Special Services	Service after hours Office service on emergency basis	$50[2] per visit

Acupuncture (Provided by Landmark Healthplan)

New Patient Evaluation	Initial evaluation, problem-focused Initial evaluation, expanded Initial evaluation (history and examination), detailed	$75 per visit
Established Patient Re-Evaluation & Management	Re-Examination, low to moderate severity	$75 per visit
Acupuncture	Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with patient Each additional 15 minutes of personal one-on-one contact with patient, with reinsertion of needle(s)	$75 per visit
Modalities	Myofascial release, trigger point therapy, or acupressure Cupping/Moxibustion	$75 per visit
Electro-acupuncture	Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with patient Each additional 15 minutes of personal one-on-one contact with patient, with reinsertion of needle(s)	$75 per visit

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

1 This rate is inclusive of covered services for initial visit/new patient evaluation, modalities, therapeutic procedures, and/or manipulation, but is exclusive of radiology. Radiology reimbursement is in addition, and is also outlined in the fee schedule.

2 This rate is inclusive of covered services for established patient re-examination, modalities, therapeutic procedures, and/or manipulation, but is exclusive of radiology. Radiology reimbursement is in addition, and is also outlined in the fee schedule.

3 There are two ChoiceBuilder® chiropractic fee schedules. To identify which fee schedule applies to the chiropractor that you wish to visit, go to Landmark Healthplan's Provider Directory by visiting www.lhp-ca.com/Members/ProviderDirectory.aspx. Under "Select Your Plan," choose "ChoiceBuilder" and then select a chiropractor using the search tools. To determine which fee schedule applies to the selected chiropractor, click on the "View Details" page for that chiropractor. Fee schedule A is listed above ($65 for new patient initial visits/$50 for recurring visits) and fee schedule B is a lower amount ($60 for new patient initial visits/$40 for recurring visits).

Chiropractic Radiology – Includes both technical and professional components of radiology services:

Radiological Exam, Chest	Ribs, unilateral, two views	$48
	Ribs, bilateral, three views	$59
	Sternum, minimum of two views	$41
	Sternoclavicular joint(s), minimum of three views	$44
Radiological Exam, Spine and Pelvis	Spine, entire, survey study, AP and lateral	$90
	Spine, single view, specify level	$30
	Cervical, AP, lateral and AP open mouth	$41
	Cervical, minimum of four views	$66
	Cervical, complete, including flexion and/or extension studies	$82
	Thoracolumbar, standing (scoliosis)	$48
	Thoracic, AP and lateral	$45
	Thoracic, AP and lateral, including swimmer's view	$53
	Thoracic, complete, minimum of four views	$57
	Thoracolumbar, AP and lateral	$48
	Scoliosis study, including supine and erect studies	$49
	Lumbosacral, AP and lateral	$45
	Lumbosacral, complete with oblique	$61
	Lumbosacral, complete with bending views	$74
	Lumbosacral, bending views only, minimum of four views	$52
	Pelvis, AP only	$41
	Pelvis, complete, minimum of three views	$49
	Sacroiliac joints, less than three views	$41
	Sacroiliac joints, three or more views	$44
	Sacrum and coccyx, minimum of two views	$41
Radiological Exam, Upper Extremities	Clavicle, complete	$33
	Scapula, complete	$37
	Shoulder, one view	$30
	Shoulder, complete, minimum of two views	$37
	Acromioclavicular joints, bilateral, weighted or unweighted	$41
	Humerus, minimum of two views	$38
	Elbow, AP and lateral views	$36
	Elbow, complete, minimum of three views	$37
	Forearm, AP and lateral views	$34
	Wrist, AP and lateral views	$34
	Wrist, complete, minimum of three views	$37
	Hand, two views	$30
	Hand, minimum of three views	$38
	Finger(s), minimum of two views	$29
Radiological Exam, Lower Extremities	Hip, unilateral, one view	$34
	Hip, complete, minimum of two views	$41
	Hips, bilateral, minimum of two views each hip	$48
	Femur, AP and lateral views	$38
	Knee, AP and lateral views	$34
	Knee, AP and lateral, including oblique(s), and tunnel, and/or patellar and/or standing views	$38
	Knee, complete, including oblique(s), and tunnel, and/or patellar and/or standing views	$41
	Both knees, standing, AP	$61
	Tibia and fibula, AP and lateral views	$34
	Ankle, AP and lateral views	$31
	Ankle, complete, minimum of three views	$38
	Foot, AP and lateral views	$31
	Foot, complete, minimum of three views	$37
	Calcaneus, minimum of two views	$31
	Toe(s), minimum of two views	$27

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

Life (Provided by Assurity Life Insurance Company) — Employer Sponsored only

Group Size	2 to 10	11 to 25	26 to 199	200 to 500
Life & AD&D Amounts	$10,000 - $25,000	$10,000 - $50,000	$10,000 - $75,000	$10,000 - $150,000
Disability Waiver of Premium	Disability prior to age 60; benefits to age 65	Disability prior to age 60; benefits to age 65	Disability prior to age 60; benefits to age 65	Disability prior to age 60; benefits to age 65
Reduction Schedule	Reduce 30% at age 70; Reduce 60% at age 75	Reduce 30% at age 70; Reduce 60% at age 75	Reduce 30% at age 70; Reduce 60% at age 75	Reduce 30% at age 70; Reduce 60% at age 75