

2025 HIGHMARK 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. 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, peridodontics, endodontics)	Major Restorative Prosthodontics, Crowns, Dentures)	Orthodontics (Medically necessary, routine braces not covered)	Orthodontic Lifetime Maximum	Annual Maximum
Blue Edge Dental F-3Wo	Individual Employee/Spouse Parent/Child(ren) Family	\$29.47 \$55.95 \$75.35 \$112.60	\$50 per member / \$150 family maximum per calendar year	N/A	\$0 Copayment (covered in full)	20% after deductible	50% after deductible	50% coinsurance (pediatric cosmetic orthodontics, no cosmetic coverage for adults), subject to lifetime max	\$1,000 per child per lifetime (Pediatric, routine braces)	\$2,000 per member per plan year

Can be purchased separately from BlueShield medical.

Valid in these counties: Albany-Clinton-Columbia-Essex-Fulton-Greene-Montgomery-Rensselaer-Saratoga-Schenectady-Schoharie-Warren and Washington.

Members can receive dental services from a provider who does not participate in the Highmark BSNEWY contracted network of providers.

Out-of-network services are reimbursed at 100% of the in-network fee schedule minus member's cost-share; the nonparticipating provider may balance bill the member for the remainder.

NOTES: Pediatric Dental PPO is now embedded in all medical plans. Simply show your medical card to your dentist.

2025 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.)
CDPHP Pediatric Basic Dental Plan 70	PEDIATRIC DENTAL COVERAGE TO AGE 19: \$16.49 per child (aged 18 and under; up to 3) will be added to the premium shown for Parent/Child(ren) or Family rates.							
	Individual (up to 3 children per family)	\$16.49	\$65 per person	100% Covered	50% Covered	50% Covered	50% covered for medical necessity only. 12-month waiting period.	Waived for D/P

2025 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	\$42.15		100% covered	100% coverage after	80% coverage after	60% coverage after	50% coverage after	Not available.	\$1,000 max per covered person per calendar year
	Employee/Spouse	\$100.17			\$50 deductible per covered person	\$50 deductible per covered person	\$50 deductible per covered person (6-month Waiting Period)	\$50 deductible per covered person (6-month Waiting Period)		
	Parent/Child(ren)	\$110.40								
	Family	\$169.41								
DENTAL NETWORKS: For maximum In-Network Benefits, please use dentists in the following networks - DentalGuard Pref-Syracuse Buy-Up and DentalGuard Pref-Syracuse.										