2027	CDPHP DELTA DENTAL PPO+ PREMIER Plan K - Small Business ONLY						No change in Rates for 2027	
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 Premier Plan K Traditional Option	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

2027	GUARDIAN DENTAL - Small Business or Individual (Sole Proprietor)						Rates in effect through 12/31/2027			
CARRIER	Tier	Rate Per Month		Preventive Care	Restoration & Oral Surgery: IN NETWORK	Highmark	Endodontics & Periodontics: IN NETWORK	Endodontics & Periodontics	Orthodontics	Maximum Benefit
GUARDIAN DENTAL PPO Z1 Class 2	Individual Employee/Spouse Parent/Child(ren) Family	$43.84 $104.18 $114.82 $176.19		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
	DENTAL NETWORKS: For maximum In-Network Benefits, please use dentists in the following networks - DentalGuard Pref-Syracuse Buy-Up and DentalGuard Pref-Syracuse.									

2027	HIGHMARK BLUESHIELD OF NORTHEASTERN NEW YORK - Small Businesses							Rates effective to 12/31/2027		
	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, perdiodontics, endodontics)	Major Restorative Prosthodontics, Crowns, Dentures)	Orthodontics (Medically necessary, routine braces not covered)	Orthodonic Lifetime Maximum	Annual Maximum
Blue Edge Dental F-3Wo	Individual Employee/Spouse Parent/Child(ren) Family	$32.48 $61.66 $83.05 $124.20	$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 max per member per plan year
	Can be purchased separately from Highmark BSNENY medical.									
	NETWORK: Elite Prime									
	Rates shown cover dependants to Age 26.									
	Valid in these counties: Albany-Clinton-Columbia-Essex-Fulton-Greene-Mongomery-Rensselaer-Saratoga-Schenectady-Schoharie-Warren and Washington.									
	Members can receive dental services from a provider who does not participate in the Highmark BSNENY 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.									

2027	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 Employee/Spouse Parent/Child(ren) Family	$55.76 $108.72 $105.92 $158.88	$64.60 $125.95 $121.43 $182.78	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
	* 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
	INFORMATION SHOWN FOR EXISTING SUBSCRIBERS ONLY.										