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Affordable, Fixed Price[1] Per Employee Available in:

Level 2 | Region 1

Delta Dental of New York PPO℠	GOOD		BETTER (5-99)		BETTER PLUS (5-99)		BEST (5-99)	
PLAN BENEFITS	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**
Dental								
Network	Delta Dental PPO [2]		Delta Dental PPO [2]		Delta Dental PPO Plus Premier [3]		Delta Dental PPO Plus Premier [3]	
Calendar Year Max (per patient)	$1,000	$750	$1,500	$1,250	$1,500	$1,250	$2,000	$1,500
Calendar Year Deductible (per patient)	• $50 • D&P: Waived	• $75 • D&P: Not waived	• $50 • D&P: Waived	• $75 • D&P: Not waived	• $50 • D&P: Waived	• $75 • D&P:Not waived	• $50 • D&P: Waived	• $75 • D&P: Waived
Diagnostic & Preventive Services (D&P)	100%	50%	100%	80%	100%	80%	100%	100%
Basic, Oral Surgery, Endodontics, and Periodontics	80%	50%	80%		80%		80%	
Major Services	50%		50%		50%		50%	
Orthodontics—Children Only	Not available		50% lifetime max $1,000		50% lifetime max $1,000		50% lifetime max $1,000	
Vision	**VSP Choice Network**							
Annual Copayment	$25 exam/$25 prescription glasses		$10 exam/$25 prescription glasses		$10 exam/$25 prescription glasses		$10 exam/$25 prescription glasses	
Frames	$150 allowance	$70*	$150 allowance	$70*	$150 allowance	$70*	$175 allowance	$70*
Contact Lenses	$150 allowance	$105*	$150 allowance	$105*	$150 allowance	$105*	$175 allowance	$105*
Eye Exam	Covered in full after copay	$45*	Covered in full after copay	$45*	Covered in full after copay	$45*	Covered in full after copay	$45*
Single-vision Lenses		$30*		$30*		$30*		$30*
Bifocal Lenses		$50*		$50*		$50*		$50*
Trifocal Lenses		$65*		$65*		$65*		$65*
Frequency								
Eye Exam	12 months		12 months		12 months		12 months	
Lenses	24 months		12 months		12 months		12 months	
Frames	24 months		24 months		24 months		12 months	
Contact Lenses (in lieu of lenses)	24 months		12 months		12 months		12 months	
Life	**Unum Basic Group Term Life with AD&D and EAP**							
Policy	$15,000		$20,000		$20,000		$25,000	

ZIP Code Regions

Region 1:
This region includes
ZIP Codes: 100–102

	EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2
(5-99)	$48.50	$91	$127	$60.50	$115	$167.50	$67	$129.50	$187.50	$77	$147	$214
(2-4)	$52.50	$98.50	$137.50									

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DELTA DENTAL | VSP VISION | UNUM

Dental | Vision | Life

[1] Rates may vary based on employer rating region, size, and industry code, and are effective January 1, 2023 through December 31, 2023. While the information and rates provided in this guide are believed to be accurate as of the print date, they are subject to change without notice. Please consult and verify with your broker for the most up-to-date information. DeltaCare® USA bundles are also available.

[2] All dentists (in- and out-of-network) are reimbursed at the lesser of the submitted charge or the Delta Dental PPO provider contracted fee.

[3] Delta Dental PPO dentists are reimbursed at the lesser of the submitted charge or the PPO provider's contracted fee. Delta Dental Premier dentists are reimbursed at the lesser of the submitted charge or the Premier provider's contracted fee. Non-contracted dentists are reimbursed at the lesser of the submitted charge or the plan contract allowance.

* Reimbursed up to.

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Affordable, Fixed Price[1] Per Employee Available in:

Level 2 | Region 2

Delta Dental of New York PPO℠	GOOD		BETTER (5-99)		BETTER PLUS (5-99)		BEST (5-99)	
PLAN BENEFITS	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**
Dental								
Network	Delta Dental PPO [2]		Delta Dental PPO [2]		Delta Dental PPO Plus Premier [3]		Delta Dental PPO Plus Premier [3]	
Calendar Year Max (per patient)	$1,000	$750	$1,500	$1,250	$1,500	$1,250	$2,000	$1,500
Calendar Year Deductible (per patient)	• $50 • D&P: Waived	• $75 • D&P: Not waived	• $50 • D&P: Waived	• $75 • D&P: Not waived	• $50 • D&P: Waived	• $75 • D&P:Not waived	• $50 • D&P: Waived	• $75 • D&P: Waived
Diagnostic & Preventive Services (D&P)	100%	50%	100%	80%	100%	80%	100%	100%
Basic, Oral Surgery, Endodontics, and Periodontics	80%	50%	80%		80%		80%	
Major Services	50%		50%		50%		50%	
Orthodontics—Children Only	Not available		50% lifetime max $1,000		50% lifetime max $1,000		50% lifetime max $1,000	
Vision	**VSP Choice Network**							
Annual Copayment	$25 exam/$25 prescription glasses		$10 exam/$25 prescription glasses		$10 exam/$25 prescription glasses		$10 exam/$25 prescription glasses	
Frames	$150 allowance	$70*	$150 allowance	$70*	$150 allowance	$70*	$175 allowance	$70*
Contact Lenses	$150 allowance	$105*	$150 allowance	$105*	$150 allowance	$105*	$175 allowance	$105*
Eye Exam	Covered in full after copay	$45*	Covered in full after copay	$45*	Covered in full after copay	$45*	Covered in full after copay	$45*
Single-vision Lenses		$30*		$30*		$30*		$30*
Bifocal Lenses		$50*		$50*		$50*		$50*
Trifocal Lenses		$65*		$65*		$65*		$65*
Frequency								
Eye Exam	12 months		12 months		12 months		12 months	
Lenses	24 months		12 months		12 months		12 months	
Frames	24 months		24 months		24 months		12 months	
Contact Lenses (in lieu of lenses)	24 months		12 months		12 months		12 months	
Life	**Unum Basic Group Term Life with AD&D and EAP**							
Policy	$15,000		$20,000		$20,000		$25,000	

ZIP Code Regions

Region 2: 103-119, 124 (Orange), 125 (Orange, Putnam), 127 (Orange)

	EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2
(5-99)	$46	$86	$120	$57.50	$109.50	$158	$66	$126.50	$183.50	$76	$144	$210
(2-4)	$49.50	$94	$129.50									

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DELTA DENTAL | VSP VISION | UNUM

Dental | Vision | Life

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CPS-010_NY L2R2 12/22

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Affordable, Fixed Price[1] Per Employee Available in:

Level 2 | Region 3

Delta Dental of New York PPO℠	GOOD		BETTER (5-99)		BETTER PLUS (5-99)		BEST (5-99)	
PLAN BENEFITS	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**	**PPO Dentists**	**Non-PPO Dentists**
Dental								
Network	Delta Dental PPO [2]		Delta Dental PPO [2]		Delta Dental PPO Plus Premier [3]		Delta Dental PPO Plus Premier [3]	
Calendar Year Max (per patient)	$1,000	$750	$1,500	$1,250	$1,500	$1,250	$2,000	$1,500
Calendar Year Deductible (per patient)	• $50 • D&P: Waived	• $75 • D&P: Not waived	• $50 • D&P: Waived	• $75 • D&P: Not waived	• $50 • D&P: Waived	• $75 • D&P:Not waived	• $50 • D&P: Waived	• $75 • D&P: Waived
Diagnostic & Preventive Services (D&P)	100%	50%	100%	80%	100%	80%	100%	100%
Basic, Oral Surgery, Endodontics, and Periodontics	80%	50%	80%		80%		80%	
Major Services	50%		50%		50%		50%	
Orthodontics—Children Only	Not available		50% lifetime max $1,000		50% lifetime max $1,000		50% lifetime max $1,000	
Vision	**VSP Choice Network**							
Annual Copayment	$25 exam/$25 prescription glasses		$10 exam/$25 prescription glasses		$10 exam/$25 prescription glasses		$10 exam/$25 prescription glasses	
Frames	$150 allowance	$70*	$150 allowance	$70*	$150 allowance	$70*	$175 allowance	$70*
Contact Lenses	$150 allowance	$105*	$150 allowance	$105*	$150 allowance	$105*	$175 allowance	$105*
Eye Exam	Covered in full after copay	$45*	Covered in full after copay	$45*	Covered in full after copay	$45*	Covered in full after copay	$45*
Single-vision Lenses		$30*		$30*		$30*		$30*
Bifocal Lenses		$50*		$50*		$50*		$50*
Trifocal Lenses		$65*		$65*		$65*		$65*
Frequency								
Eye Exam	12 months		12 months		12 months		12 months	
Lenses	24 months		12 months		12 months		12 months	
Frames	24 months		24 months		24 months		12 months	
Contact Lenses (in lieu of lenses)	24 months		12 months		12 months		12 months	
Life	**Unum Basic Group Term Life with AD&D and EAP**							
Policy	$15,000		$20,000		$20,000		$25,000	

ZIP Code Regions

Region 3: This region includes ZIP Codes: 120-123, 124 (Ulster, Albany, Delaware, Greene) 125 (Ulster, Columbia, Dutchess), 126, 127 (Delaware, Sullivan, Ulster), 128-149

	EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2
(5-99)	$36	$66	$91.50	$46	$83.50	$120.50	$51.50	$96	$138.50	$59.50	$110.50	$159.00
(2-4)	$39	$71	$99									

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DELTA DENTAL | VSP VISION | UNUM

Dental | Vision | Life

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