2027 Dental Selection Form: **Delta Dental of New York**

Delta Dental PPO[SM] Plans
Available to groups with 300 eligibles or less.

	BASIC OPTION	ESSENTIAL OPTION	TRADITIONAL OPTION	COMPREHENSIVE OPTION
Diagnostic	100%	100%	100%	100%
Preventive	100%	100%	100%	100%
Basic Restorative	50%	50%	80%	80%
Oral Surgery	0%	50%	80%	80%
Endodontics	0%	50%	80%	80%
Periodontics	0%	50%	80%	80%
Major Restorative	0%	50%	50%	50%
Prosthodontics	0%	50%	50%	50%
Implants	0%	50%	50%	50%
TMJ (temporomandibular joint)	50%	50%	50%	50%
Orthodontics	0%	0%	0%	50%
Annual Maximum	$1,500	$1,500	$1,500**	$2,000**
Ortho Maximum	N/A	N/A	N/A	$1,000
Out-of-Pocket Maximum per Individual	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum per 2+ Individuals	N/A	N/A	N/A	N/A
Deductible/Individual	$25	$50	$25	$50
Deductible/Family	$75	$150	$75	$150
Deductible waived for Diagnostic and Preventive	Yes	Yes	Yes	Yes
Annual Maximum waived for Diagnostic and Preventive	No	No	Yes	Yes

Pediatric Plan

DELTA DENTAL PPO PEDIATRIC BASIC PLAN
100%
100%
50%
50%
50%
50%
50%
50%
0%
50%
50%*
N/A
N/A
$450 for Delta Dental PPO providers. No maximum for Delta Dental Premier® or non-Delta Dental providers***
$900 for Delta Dental PPO providers. No maximum for Delta Dental Premier® or non-Delta Dental providers***
$65
$195
No
N/A

* Orthodontic services are covered for medical necessity only.

over

** Diagnostic and preventive services do not contribute to the annual maximum.

*** After the annual out-of-pocket maximum has been fulfilled, applicable services are covered at 100% .

Note: Percentages are based on Delta Dental's applicable maximum plan allowance or dentist's actual fee, whichever is less.

2027 Dental Selection Form: **Delta Dental of New York**

Rates apply to groups headquartered in the CDPHP 12-county service area. Monthly plan rates are valid for effective dates: January 1, 2027 through December 1, 2027.

Important notes regarding Pediatric Plan :

Small Groups Only — In accordance with the essential pediatric dental coverage requirement outlined in the Affordable Care Act, any employee (and applicable dependents) that enroll in a business plan will be automatically enrolled in the Pediatric Plan. Rates will be billed for each family member who is 18 years old or younger.

MONTHLY RATES

Commercial Delta Dental PPO℠ Plans**
Available to groups with 300 eligibles or less.

	BASIC OPTION		ESSENTIAL OPTION		TRADITIONAL OPTION		COMPREHENSIVE OPTION	
NETWORK	**PPO**	**PPO+ PREMIER**	**PPO**	**PPO+ PRE-MIER**	**PPO**	**PPO+ PREMIER**	**PPO**	**PPO+ PREMIER**
Albany Area Monthly Rate per Individual < 19	N/A							
Mid-Hudson Area Monthly Rate per Individual < 19								
Employee Only	$13.78	$19.24	$26.79	$35.02	$34.83	$45.55	$34.38	$42.44
Employee & Spouse	$30.18	$42.12	$57.07	$74.57	$73.76	$96.39	$73.24	$90.41
Employee & Child(ren)	$35.86	$43.96	$50.99	$66.64	$70.48	$92.11	$71.77	$87.68
Employee & Family	$51.73	$63.42	$83.02	$108.50	$112.24	$146.70	$116.31	$141.84
SELECT YOUR PLAN								
CHOOSE YOUR PLAN *Please review all options and select ONE from this row*	24000003 Plan C ◯	24000004 Plan D ◯	24000006 Plan F ◯	24000007 Plan G ◯	24000010 Plan J ◯	24000011 Plan K ◯	24000012 Plan L ◯	24000013 Plan M ◯

Pediatric Plan*

DELTA DENTAL PPO PEDIATRIC BASIC PLAN
PPO
$16.49
$18.45
N/A
Plan 70 ◯

Previous Group Dental Insurance: ◯ Yes ◯ No – Waiting period applies for groups with less than 25 eligibles

Group Name	Group Number	Effective Date
Broker	Tax ID Number	

The Company agrees to execute a group contract with the same Effective Date and dental plan selection within 90 days hereof.

Employer Signature	Print Name	Date

CDPHN receives variable compensation from Delta Dental of New York, Inc., based in whole or in part on types of contracts and volume sold. You may contact CDPHN directly to obtain information about this compensation.

* Rates for the pediatric plan are capped at three individuals.

** Rates include Delta Dental SmileWay benefits for eligible members, see plan highlights for more details.