

# NMRHCA 2018 Dental Plan Comparison

UNITED CONCORDIA DENTAL - ALLIANCE NETWORK					DELTA DENTAL - PPO NEW MEXICO NETWORK				
BENEFIT CATEGORY	BASIC PLAN		COMPREHENSIVE PLAN		BENEFIT CATEGORY	BASIC PLAN		COMPREHENSIVE PLAN	
	In-Network Plan Pays	Out-of-Network Plan Pays	In-Network Plan Pays	Out-of-Network Plan Pays		In-Network Plan Pays	Out-of-Network Plan Pays	In-Network Plan Pays	Out-of-Network Plan Pays
<b>Diagnostic and Preventive Services</b>					<b>Diagnostic and Preventive Services</b>				
Routine Oral Exams (three per 12 months)	100% No Deductible	25% of Allowed Amount	100% No Deductible	100% of Allowed Amount No Deductible	Oral Exams (two routine per calendar year plus one problem-focused/emergency, if needed.)	100% No Deductible	25% of Allowed Amount No Deductible	100% No Deductible	75% of Allowed Amount No Deductible
Routine Cleanings (three per 12 months)					Routine Cleanings (two per calendar year or up to two additional for specified at-risk medical conditions)				
X-rays (complete mouth-once every 5 years; bitewings two sets per 12 months through age 13 once every 12 months thereafter)					Radiographic images (full mouth-once every 5 years; bitewings twice in a calendar year)				
Emergency Treatment for Relief of Pain					Emergency Treatment for Relief of Pain				
<b>Basic Services</b>					<b>Basic Services</b>				
Amalgam and Composite Fillings	80%	25% of Allowed Amount	80%	55% of Allowed Amount	Basic Restorative (amalgam or composite fillings)	80%	25% of Allowed Amount	80%	55% of Allowed Amount
Simple Extractions					Simple Extractions (non-surgical)				
Endodontics					Endodontics				
Nonsurgical Periodontics	Not Covered		80%	55% of Allowed Amount	Nonsurgical Periodontics	Not Covered		80%	55% of Allowed Amount
Complex Oral Surgery (covered on Comprehensive Plan only)					Oral Surgery (including surgical extractions)				
Surgical Periodontics (covered on Comprehensive Plan only)	Not Covered		80%	55% of Allowed Amount	Surgical Periodontics	Not Covered		80%	55% of Allowed Amount
Repair to Onlays, Crowns, Dentures and Bridgework					Repairs to Crowns, Onlays, Dentures and Bridgework				
Repair to Onlays, Crowns, Dentures and Bridgework	80%	25% of Allowed Amount				80%	25% of Allowed Amount		
<b>Major Services</b>					<b>Major Services</b>				
Removeable Partial or Complete Dentures and Fixed Bridges	Not Covered		50%	35% of Allowed Amount	Prosthodontic procedures for construction of fixed bridges, partials or complete dentures	Not Covered		50%	35% of Allowed Amount
Implants and Implant Related Services					Implants - specified services, including repairs, and related prosthodontics, subject to clinical review/approval				
Onlays and Crowns (when teeth cannot be restored to normal form and function with amalgam, composite resin or plastic fillings)					Onlays, Crowns and Cast Restorations - when teeth cannot be restored with amalgam or composite resin restorations				
<b>Orthodontics</b>					<b>Orthodontics</b>				
Diagnostic, Active, Retention Treatment In and out-of-network lifetime maximums cannot be combined.	Not Covered		50% No Deductible \$1000 Lifetime Max	50% of Allowed Amount No Deductible \$500 Lifetime Max	Diagnostic, Active, Retention Treatment In and out-of-network lifetime maximums cannot be combined.	Not Covered		50% No Deductible \$1000 Lifetime Max	50% of Allowed Amount No Deductible \$500 Lifetime Max
<b>Deductibles and Maximums</b>					<b>Deductibles and Maximums</b>				
Calendar Year Deductible - Jan 1 thru Dec 31. Applies to all services except where noted above.	\$50 (\$150 Per Family)		\$50 (\$150 per family)		Calendar Year Deductible - Jan 1 thru Dec 31. Applies to all services except where noted above.	\$50 (\$150 Per Family)		\$50 (\$150 per family)	
Calendar Year Maximum - Jan 1 thru Dec 31 (per person). In and out-of-network annual maximums cannot be combined.	\$1,500.00		\$1,500.00	\$1,000.00	Calendar Year Maximum - Jan 1 thru Dec 31 (per person). In and out-of-network annual maximums cannot be combined.	\$1,500.00	\$1,500.00	\$1,500.00	\$1,000.00

Important Note: Lowest out-of-pocket costs apply In-Network. Non-Participating Providers may balance bill patients for charges over the allowed amount (up to the full amount of submitted charges).

This Benefit Comparison has been prepared as a general description to highlight some of the benefits available under your dental plan options.

It does not reflect all benefits, limitations, exclusions, or provide complete coverage information. Complete coverage descriptions are provided by the dental plan carrier when you enroll.