

# PPO SMALL GROUP 2022

## OHIO

2-50 ELIGIBLE  
EMPLOYEES

The Dental Care  
PLUS GROUP

A DentaQuest Company

Good for effective dates of January 1 through December 1, 2022. Not available in the following Ohio counties: Hamilton, Butler, Clermont and Warren.

ADDITIONAL PLAN DESIGNS ARE AVAILABLE FOR GROUPS WITH 10-50 ELIGIBLE EMPLOYEES.

|   | Option 1<br>In-/Out-of-Network                |           | Option 2<br>In-/Out-of-Network |           | Option 3<br>In-/Out-of-Network |           |
|---|---|-----------|--------------------------------|-----------|--------------------------------|-----------|
| Copay   | \$0   |           | \$0                            |           | \$0                            |           |
| Deductible (Individual/Family)  | \$50/\$150                                    |           | \$50/\$150                     |           | \$50/\$150                     |           |
| Annual Maximum  | \$1,500                                       |           | \$1,000                        |           | \$1,000                        |           |
| Preventive  | 100%/100%                                     |           | 100%/100%                      |           | 100%/100%                      |           |
| Basic   | 80%/50%                                       |           | 80%/80%                        |           | 90%/90%                        |           |
| Major   | 50%/25%                                       |           | 50%/50%                        |           | 60%/60%                        |           |
| Orthodontia (optional)  | 50% to \$1,000                                |           | 50% to \$1,000                 |           | 50% to \$1,000                 |           |
| Endodontics & Periodontics  | Major   |           | Major                          |           | Major                          |           |
| <b>Without Orthodontia</b>  |   |           |                                |           |                                |           |
|   | Contributory                                  | Voluntary | Contributory                   | Voluntary | Contributory                   | Voluntary |
| Employee  | \$22.23                                       | \$23.56   | \$23.15                        | \$24.54   | \$25.01                        | \$26.51   |
| Employee/Spouse   | \$44.45                                       | \$47.11   | \$46.30                        | \$49.08   | \$50.00                        | \$53.01   |
| Employee/Child(ren)   | \$46.68                                       | \$49.48   | \$48.63                        | \$51.54   | \$52.52                        | \$55.66   |
| Family  | \$73.35                                       | \$77.75   | \$76.41                        | \$80.98   | \$82.52                        | \$87.46   |
| <b>With Child Orthodontia – must have 5 employees enrolled in the plan</b>  |   |           |                                |           |                                |           |
|   | Contributory                                  | Voluntary | Contributory                   | Voluntary | Contributory                   | Voluntary |
| Employee  | \$22.23                                       | \$23.56   | \$23.15                        | \$24.54   | \$25.01                        | \$26.51   |
| Employee/Spouse   | \$44.45                                       | \$47.11   | \$46.30                        | \$49.08   | \$50.00                        | \$53.01   |
| Employee/Child(ren)   | \$55.19                                       | \$58.51   | \$57.49                        | \$60.93   | \$62.09                        | \$65.81   |
| Family  | \$85.63                                       | \$90.77   | \$89.20                        | \$94.54   | \$96.33                        | \$102.11  |
| <b>Additional Options</b>   |   |           |                                |           |                                |           |
| Add \$10 preventive copay   | Reduce 4%                                     |           | Reduce 4%                      |           | Reduce 4%                      |           |
| To change deductible to \$25/\$75   | Add 3%  |           | Add 3%                         |           | Add 3%                         |           |
| No Deductible   | Add 6%  |           | Add 6%                         |           | Add 6%                         |           |
| Periodontics in Basic   | Add 2%  |           | Add 2%                         |           | Add 2%                         |           |
| Endodontics in Basic  | Add 4%  |           | Add 4%                         |           | Add 4%                         |           |
| Implants  | Add 2%  |           | Add 2%                         |           | Add 2%                         |           |
| \$1,000 Annual Max  | Reduce 4%                                     |           | N/A                            |           | N/A                            |           |
| \$1,500 Annual Max  | N/A   |           | Add 6%                         |           | Add 6%                         |           |
| <b>Out-of-Network Reimbursement Options – Rates listed above are based on an out-of-network reimbursement level at Match (fee schedule)</b> |   |           |                                |           |                                |           |
| Defined 800   | Add 3%  |           | Add 3%                         |           | Add 3%                         |           |
| Advantage 900   | Add 6%  |           | Add 6%                         |           | Add 6%                         |           |
| <b>Bundle with Fully-Insured Vision for Additional Savings</b>  |   |           |                                |           |                                |           |
| Add Vision  | Reduce 2%                                     |           | Reduce 2%                      |           | Reduce 2%                      |           |
| <b>Commission – Rates listed above assume the DCPG standard agent compensation schedule</b>   |   |           |                                |           |                                |           |
| Flat 10%  | For a flat 10% commission add 5% to the rates |           |                                |           |                                |           |

## Plan Features

No waiting periods. Fourth quarter deductible carryover. Composite/white fillings on anterior and posterior teeth. Annual open enrollment. The EPIC Hearing Service Plan is included. The TVS/Coast to Coast discount vision plan is included. Members can easily search for participating providers in the DentaSelect Plus or Balanced Value networks by using our Find a Dentist tool at: [fad.dentalcareplus.com](http://fad.dentalcareplus.com).

Please contact your sales representative at **800-367-9466** for details or visit [DentalCarePlus.com](http://DentalCarePlus.com).

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## OHIO

### Underwriting Guidelines

**Current DCPG groups are not eligible for these shelf rate plans.** Groups that have terminated coverage with DCPG are not eligible for the New Sale Shelf Rates for two years from the date of termination. The plan requires a minimum enrollment of 25% of the total eligible employees upon initial implementation and upon the plan's annual anniversary date. This enrollment must represent a minimum of two contracts. Contributory rates require a minimum employer contribution of 50% of the employee-only rate. Deductibles apply to Basic and Major services only. Preventive copays apply to routine cleanings and oral exams only. Dependents are covered to age 26. Child orthodontia covers eligible dependents to age 19. **Rates guaranteed for 2 years from time of initial effective date.** Plans effective for the 1st of the month effective dates only. EFT premium payment required for groups with 2-9 eligible employees. Members who receive services from a participating provider in our DentaSelect Plus network will receive a higher level of benefits.