ITHACA CITY SCHOOL DISTRICT - All Members

FULLY INSURED DENTAL BENEFITS

DENTAL SERVICES	LIFETIME Current	AMERITAS Low	AMERITAS Medium	AMERITAS High
Preventative	100% / 100%	100% / 100%	100% / 100%	100% / 100%
Basic	100% / 100%	100% / 100%	80% / 80%	90% / 80%
Major	100% / 100%	100% / 100%	50% / 50%	60% / 50%
Ortho	Not Covered	Not Covered	50% / 50%	50% / 50%
Child Age Limits	19 / 25	19 / 25	19 / 25	19 / 25
Individual Deductible	$0	$0	$50	$50
Family Deductible	$0	$0	$150	$150
Deductible Class	N/A	N/A	Waived for Preventative	Waived for Preventative
Annual Benefit Maximum	Unlimited	$3,000	$1,000	$1,500
Orthodontia Benefit Maximum (Children under age 19 Only)	N/A	N/A	$1,000	$1,000
Claim Payment Basis	Schedule A	MCE Fee Schedule / MCE Fee Schedule	Discount Fee Schedule / Discount Fee Schedule	Discount Fee Schedule / 90th UCR
In-Network Balance Billing	Allowed up to Charge	Allowed up to Discount Fee Schedule	Not Allowed	Not Allowed
Standard Waiting Periods	None	None	None	None
Fusion	No	Included $150	Included $150	Included $150
Lasik Advantage Benefit	No	Year 1 - $400 Year 2 - $800	Year 1 - $400 Year 2 - $800	Year 1 - $400 Year 2 - $800
Maximum Rollover / Dental Rewards	No	Yes	Yes	Yes
Network	None	Ameritas	Ameritas	Ameritas

Once you enroll in dental coverage, you may not make any changes to your coverage for two years.

Definitions:

Fee Schedule– The schedule (attached) that Ameritas uses to determine the amount to be reimbursed for a service. Varies by zip code and dentist.

Balance Billing– Ameritas does not allow their contracted, in-network providers to bill you outside of the fee schedule. Out-of-network providers may bill you above and beyond what the fee schedule allows. (see examples on next page)

Coinsurance– The percent listed above is the portion of the allowed amount on the fee schedule that Ameritas will pay for a service. You are responsible to pay the additional amount (see examples below)

Fusion– You may use up to $150 of your unused annual maximum towards eye care expenses. This is a reimbursement program that does not require a network and is separate from your vision plan.

Dental Rewards– If you have at least one dental claim per year and you use less than $750 of your annual maximum, you may roll over up to $400 per year of your unused annual maximum into the next plan year. You can earn an additional $200 rollover bonus for visiting an in-network provider. The maximum amount of rollover you can accummulate is an additional $1,200 per person.

Lasik Advantage– This benefit increases over time and is available only to members who are age 18 or older unless medically necessary. This is a reimbursement program that does not require a network and is separate from your vision plan.

Claim Examples

SERVICE TYPE	ADA CODE	DENTAL SERVICES	DENTIST CHARGES Average Est.	CURRENT Allowance (LBS)	AMERITAS Low In & Out of Network	AMERITAS Medium In Network	AMERITAS Medium Out of Network	AMERITAS High In Network	AMERITAS High Out of Network
EXAMPLE 1: Routine Check-up									
PREV	0120	Oral Exam (periodic)	$62.00	$8.00	$8.00	$24.00	$24.00	$24.00	$57.00
PREV	1110	Prophylaxis, Adult	$100.00	$12.00	$12.00	$58.00	$58.00	$58.00	$104.00
			$162.00	$20.00	$20.00	$82.00	$82.00	$82.00	$161.00
		Out of Pocket Expense		$142.00	$142.00	Paid in Full	$80.00	Paid in Full	$1.00
EXAMPLE 2: Filling									
PREV	0120	Oral Exam (periodic)	$62.00	$8.00	$8.00	$24.00	$24.00	$24.00	$57.00
BASIC	2140	Amalgam Filling	$172.00	$12.00	$20.00	$59.20	$59.20	$66.60	$130.40
			$234.00	$20.00	$28.00	$83.20	$83.20	$90.60	$187.40
		Out of Pocket Expense		$214.00	$206.00	$14.80	$150.80	$7.40	$46.60
EXAMPLE 3: Crown									
PREV	0120	Oral Exam (periodic)	$62.00	$8.00	$8.00	$24.00	$24.00	$24.00	$57.00
PREV	0220	Single Film X-ray	$34.00	$5.00	$5.00	$14.00	$14.00	$14.00	$32.00
MAJOR	6750	Crown - procelain fused to noble metal	$1,316.00	Not Covered	$130.00	$375.50	$375.50	$450.60	$667.00
			$1,412.00	$13.00	$143.00	$413.50	$413.50	$488.60	$756.00
		Out of Pocket Expense		$1,399.00	$1,269.00	$375.50	$998.50	$300.40	$656.00
		= Paid at 80% of Schedule			= Paid at 90% of Schedule				
		= Paid at 50% of Schedule			= Paid at 60% of Schedule				

- Please note these examples are purely for illustrative purposes only and do not represent services preformed at an actual dental visit. -

9/6/2019
ENV Insurance Agency

ITHACA CITY SCHOOL DISTRICT

SAMPLE DENTAL FEE SCHEDULE COMPARISON

ADA CODE	DENTAL SERVICES	LIFETIME SCHEDULE A	AMERITAS MCE SCHEDULE	AMERITAS DISCOUNT FEE	AMERITAS 90th UCR
DIAGNOSTIC/PREVENTIVE					
0120	Oral Exams	$8.00	$8.00	$24.00	$57.00
0150	Comprehensive Exam	$8.00	$12.00	$38.00	$90.00
0210	Complete Series X-ray	$31.00	$26.00	$79.00	$149.00
0220	Single film X-ray	$5.00	$5.00	$14.00	$32.00
0272	Bitewing X-ray	$8.00	$7.00	$25.00	$53.00
1110	Prophylaxis, Adult	$12.00	$17.00	$58.00	$104.00
1120	Prophylaxis, Child	$10.00	$12.00	$42.00	$73.00
BASIC					
2140	Amalgam Filling, Adult-One surface	$12.00	$20.00	$74.00	$163.00
3310	Root Canal, Anterior	$120.00	$123.00	$480.00	$1,012.00
3330	Root Canal, Molar	$185.00	$190.00	$742.00	$1,355.00
4341	Root planning & Scaling, per quadrant	Not Covered	$25.00	$146.00	$298.00
7140	Simple Extraction	$20.00	$22.00	$93.00	$198.00
7240	Extraction, Full bony Impaction	$85.00	$83.00	$276.00	$564.00
MAJOR					
2750	Crown- Porcelain with Semiprecious Metal	$245.00	$199.00	$778.00	$1,301.00
5110	Full upper denture	Not Covered	$132.00	$972.00	$1,799.00
5213	Partial denture, upper	Not Covered	Not Covered	$1,085.00	$1,975.00
6240	Pontic- porcelain fused to noble metal	Not Covered	$120.00	$716.00	$1,393.00
6250	Resin with high noble metal	Not Covered	Not Covered	$681.00	$1,276.00
6720	Crown resin with high noble metal	Not Covered	Not Covered	$809.00	$1,361.00
6750	Crown- Porcelain fused to noble metal	Not Covered	$130.00	$751.00	$1,334.00
		$749	$1,909	$7,883	$14,587

ABOVE FEES MAY VARY BY PROVIDER ZIP CODE, SERVICE CAETGORY MAY VARY BY CARRIER CONTRACT

ENV Insurance Agency 9/5/2019