State of Nebraska Dental Plan

What do you need to know?

Dental Plan Details
View the coverage details for Preventive, Basic and Major procedures.

Out-of-Pocket Cost Comparison
See how much you save by enrolling in the dental plan.

Dental Rewards
Increase your annual maximum by using your dental plan and staying under the benefit threshold.

Orthodontia and TMJ Benefits
View the coverage details for orthodontic procedures and TMJ treatment.

Click on a topic to skip ahead.
Dental Plan Covered Services
Comparing Plan Coverage - Procedures

Type 1
Preventive
- Exams and Cleanings (2 per benefit period)
- X-rays
- Sealants

Type 2
Basic
- Fillings
- Root Canals
- Gum Disease Treatment
- Extractions

Type 3
Major
- Initial and Replacement Crowns
- Dentures
- Bridges
Dental Plan Covered Services
Comparing Plan Coverage

**In-Network Coverage**
- Type 1 (Preventive): Basic Plan 80%, Premium Plan 80%
- Type 2 (Basic): Basic Plan 60%, Premium Plan 70%
- Type 3 (Major): Basic Plan 50%, Premium Plan 50%

**Out-of-Network Coverage**
- Type 1 (Preventive): Basic Plan 50%, Premium Plan Year 1 50%
- Type 2 (Basic): Basic Plan 60%, Premium Plan Year 2 60%
- Type 3 (Major): Basic Plan 25%, Premium Plans Year 3+ 30%

**Benefit Year Maximum**
- Basic: $1,000 in and out-of-network
- Premium: $1,500 in-network, $1,000 out-of-network

**Deductible (Basic and Major only)**
- $50 per individual, $150 per family
Estimated Out-of-Pocket Costs
In-Network Example

Insurance covers
Basic Plan: $1,136
Premium Plan: $1,136

Jane pays
Basic Plan: $388
Premium Plan: $388

Check with your dental provider for procedure costs. This example shows estimated amounts for ZIP Code 685XX. The amount insurance covers is calculated from the amount allowed from network providers in the area. A preventive visit is composed of an exam, cleaning and x-ray.
Estimated Out-of-Pocket Costs
Out-of-Network Example

Insurance covers
Basic Plan: $488
Premium Plan (Year 3): $634

Jane pays
Basic Plan: $1,036
Premium Plan (Year 3): $890

Check with your dental provider for procedure costs. This example shows estimated amounts for ZIP Code 685XX. The amount insurance covers is calculated from the plan's claim allowance. The member is responsible for charges above the claim allowance. A preventive visit is composed of an exam, cleaning, and x-ray.
Ameritas Dental Network

- One of the largest dental networks in the nation
- Network providers charge 25-50% below average
- Find a provider in the Classic and Plus network at ameritas.com
Dental Rewards®
Increase Your Annual Maximum

Total Amount Available for Covered Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Maximum</th>
<th>Rewards earned from Year 1 + PPO Bonus</th>
<th>Rewards earned from Year 2 + PPO Bonus</th>
<th>Rewards earned from Year 3 + PPO Bonus</th>
<th>Rewards earned from Year 4 + PPO Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$1,000</td>
<td>$350</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Year 2</td>
<td>$1,000</td>
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<td>$350</td>
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<tr>
<td>Year 3</td>
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<td>Year 4</td>
<td>$1,000</td>
<td></td>
<td></td>
<td></td>
<td>$350</td>
</tr>
</tbody>
</table>

Earn $350 in rewards each year

- Submit a claim during the benefit year
- Stay below the $500 threshold for paid claims
- Annual reward includes $250 plus $100 for visiting a network (PPO) provider
- Earn up to $1,000 in rewards
- Apply your accumulated rewards when claims exceed your annual maximum

Does not apply to orthodontic or TMJ services.
# Orthodontia and TMJ

## Basic Plan

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Ortho: Child Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TMJ: Adult and Child</td>
</tr>
<tr>
<td>Waiting Period</td>
<td>None</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Plan Benefit</td>
<td>50% in-network</td>
</tr>
<tr>
<td></td>
<td>25% out-of-network</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$2,000 combined</td>
</tr>
<tr>
<td></td>
<td>per person</td>
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</table>
# Orthodontia and TMJ

## Premium Plan

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Adult &amp; Child</th>
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<tbody>
<tr>
<td>Waiting Period</td>
<td>None</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Plan Benefit</td>
<td>50% in-network, 30% out-of-network</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$2,000 combined per person</td>
</tr>
</tbody>
</table>
Late Entrant Provisions

Late entrants are eligible for only preventive procedures during the first 12 months of coverage.
Dependent Eligibility

Children Up to Age 26

- Natural child
- Step child, in enrolled family coverage
- Legally adopted child
- Child placed with you for adoption
- Child, or grandchild, for whom you have legal guardianship or court-ordered custody

Children Over Age 26

- Child was disabled prior to age 26
- Child must be covered on the dental plan before turning 26
## Monthly Rates

<table>
<thead>
<tr>
<th></th>
<th>Basic Plan</th>
<th>Premium Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only (Single Coverage)</td>
<td>$23.84</td>
<td>$27.84</td>
</tr>
<tr>
<td>Employee + Spouse (Two-Party Coverage)</td>
<td>$47.72</td>
<td>$55.72</td>
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<tr>
<td>Employee + Dependent Children</td>
<td>$68.72</td>
<td>$80.32</td>
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<tr>
<td>(Four-Party Coverage)</td>
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<tr>
<td>Employee + Spouse + Dependent</td>
<td>$74.64</td>
<td>$87.20</td>
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<tr>
<td>Coverage (Family Coverage)</td>
<td></td>
<td></td>
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</tbody>
</table>
Secure Member Account

Plan Information
- Member ID cards
- Plan benefit summaries
- Claims processing details
- Electronic benefit statements (EOB)

Additional Features
- Find a provider
- Dental cost estimator
- Dental health report card
- Prescription savings card
- Eyewear savings card
- Worldwide assistance
Thank You

Employee Wellness & Benefits

- [link.nebraska.gov](http://link.nebraska.gov)
- In Lincoln: 402-471-4443
- Outside of Lincoln: 877-721-2228
- [as.employeebenefits@nebraska.gov](mailto:as.employeebenefits@nebraska.gov)