YOUR 2020 DENTAL PLAN COMPARISON

NVIDIA PPO DENTAL PLAN — WHAT YOU PAY

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	Individual: $50 Family: $100	Individual: $100 Family: $300
Annual Benefit Maximum	The plan pays $3,000 per covered individual	The plan pays $3,000 per covered individual
Diagnostic And Preventive Care (includes exams and cleanings, scaling and polishing, routine X-rays; full-mouth X-rays once every three years)	$0 (deductible does not apply)	10% of all fees in excess of R&C* (deductible does not apply)
Basic Care (includes fillings, extractions, root canals, stainless steel crowns, oral surgery to remove teeth, periodontics)	10% after deductible	30% of R&C* fees after deductible; 100% of all fees in excess of R&C*
Major Care (includes crowns, inlays, bridges, dentures)	40% after deductible	50% of R&C* fees after deductible; 100% of all fees in excess of R&C*
Orthodontia (for adults and children, up to a lifetime maximum of $3,000)	50% of R&C* fees after deductible	50% of R&C* fees after deductible; 100% of all fees in excess of R&C*

DELTACARE USA (DHMO) — WHAT YOU PAY

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	No deductible	Not covered
Annual Benefit Maximum	No maximum	Not covered
Diagnostic And Preventive Care (includes exams and cleanings, scaling and polishing, routine X-rays; full-mouth X-rays once every three years)	$0–$45 member copay per procedure	Not covered
Basic Care (includes fillings, extractions, root canals, stainless steel crowns, oral surgery to remove teeth, periodontics)	$0–$280 member copay per procedure	Not covered
Major Care (includes crowns, inlays, bridges, dentures)	$0–$280 member copay per procedure	Not covered
Orthodontia (for adults and children)	$1,700 child/$1,900 adult member copay, plus cost for pre/post records and retention phase	Not covered

* Reasonable and customary