Dental Plans

Nebraska Medicine

PREMIUM PLAN

	IN-NETWORK	OUT-OF-NETWORK
Deductible		
Type A – Preventive and Diagnostic	$0	$0
Type B – Restorative	$50 per person	$100 per person
Type C – Major	Combined with B	Combined with B
Coinsurance		
Type A – Preventive and Diagnostic	100%	80%
Type B – Restorative	80%	60%
Type C – Major	50%	50%
Calendar Year Maximum	***$1,500***	***$1,000***
Orthodontia		
Deductible (Lifetime)	$50 per person	$100 per person
Coinsurance	50%	50%
Maximum Lifetime Benefit	$2,000 per person	$1,000 per person

**Type A services do not apply toward calendar year maximum*

CORE PLAN

	IN-NETWORK	OUT-OF-NETWORK
Deductible		
Type A – Preventive and Diagnostic	$0	$0
Type B – Restorative	$50 per person	$100 per person
Type C – Major	Combined with B	Combined with B
Coinsurance		
Type A – Preventive and Diagnostic	100%	80%
Type B – Restorative	60%	50%
Type C – Major	40%	30%
Calendar Year Maximum	***$1,000***	***$500***
Orthodontia		
Deductible (Lifetime)	Not covered	Not covered
Coinsurance	Not covered	Not covered
Maximum Lifetime Benefit	Not covered	Not covered

**Type A services do not apply toward calendar year maximum.*

Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.

Dental Costs

2025 Costs Per Pay Period (For Full-Time and Part-Time Employees)		
PREMIUM PLAN	Employee Premium per Pay Period	Employer Premium per Pay Period
Employee Only	$14.88	$4.96
Employee/Spouse	$31.26	$10.42
Employee/Child(ren)	$28.28	$9.42
Family	$44.65	$14.88

CORE PLAN	Employee Premium per Pay Period	Employer Premium per Pay Period
Employee Only	$10.54	$3.51
Employee/Spouse	$22.13	$7.38
Employee/Child(ren)	$20.02	$6.67
Family	$31.61	$10.53