

DENTAL PLAN OVERVIEW

DELTA DENTAL PLAN	PPO + PREMIUM PLAN #1563		PPO (In-Network Only) PLAN #9098	
Annual Maximum Benefit	\$2,000 per person (combination of in and out of network)		\$2,000 (in-network only)	
Orthodontic Lifetime Maximum	\$2,000 per person (combination of in and out of network)		\$2,000 per person (in-network only)	
Plan Year Deductibles (7/1-6/30) Applies to Basic and Major only	Individual Deductible- \$50 (combination of in and out-of-network) Family Deductible- \$100 (combination of in and out-of-network)		No Deductible	
RIGHT START 4 KIDS	Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier provider to receive the 100% coinsurance. If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontics, if selected as part of the group's plan, is not covered at 100% but at the plan's listed coinsurance..		Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO provider to receive the 100% coinsurance. Orthodontics, if selected as part of the group's plan, is not covered at 100% but at the plan's listed coinsurance.	
	PPO Dentist	Premier/ Non-PPO Dentist	PPO Dentist	Premier/ Non-PPO Dentist
	In-Network	Out-of-Network	In-Network	Out-of-Network
PREVENTATIVE AND DIAGNOSTIC SERVICES				
Oral Evaluation	100% Covered Limited to 2 evaluations in a 12 month period	100% Covered	100% Covered Limited to 2 evaluations in a 12 month period	Not Covered
Bitewing X-Rays	100% Covered Limited to 2 sets in a 12 month period	100% Covered	100% Covered Limited to 1 set in a 12 month period	Not Covered
Full Mouth X-Rays or Panoramic	100% Covered Limited to 1 in a 36 month period	100% Covered	100% Covered Limited to 1 in a 60 month period	Not Covered
Routine Cleaning	100% Covered Limited to 2 cleanings in a 12 month period – if patient history shows prior	100% Covered	100% Covered Limited to 2 cleanings in a 12 month period	Not Covered
Fluoride Treatment	100% Covered Limited to 1 treatment in 12 months to age 16	100% Covered	100% Covered Limited to 1 treatment in 12 months to age 16	Not Covered
Space Maintainers	100% Covered For posterior primary teeth- to age 14	100% Covered	100% Covered For posterior primary teeth- to age 14	Not Covered
Sealants	100% Covered 1 per tooth in 36 months- to age 15 on unrestored molars	100% Covered	100% Covered 1 per tooth in 36 months- to age 15 on unrestored molars	Not Covered
BASIC SERVICES [Fillings, Endodontics (Root Canal), Periodontics (Gum Disease), Oral Surgery (extractions), and Denture repairs]				
Amalgam Fillings	80% Covered Benefits on the same surface limited to 1 in 12 months	75% Covered	60% Covered Benefits on the same surface limited to 1 in 12 months	Not Covered
Resin or Composite Fillings	80% Covered Benefit for anterior teeth only- allowance for amalgam on posterior teeth	75% Covered	60% Covered Benefits on the same surface limited top 1 in 12 months	Not Covered
General Anesthesia	80% Covered Benefit with covered oral surgery only	75% Covered	60% Covered Benefit with covered oral surgery only	Not Covered
Surgical Periodontal (gums)	80% Covered Benefit once every 36 months	75% Covered	60% Covered Benefit once every 36 months	Not Covered
Root Canal Therapy	80% Covered	75% Covered	60% Covered	Not Covered
Denture Repairs/Rebase/Relines	80% Covered Benefits limited to 1 in 12 months	75% Covered	60% Covered Benefit 6 months after initial insertion. Then benefit 1 in 36 months	Not Covered
MAJOR SERVICES (Crowns, Bridges, Partials, Dentures)				
Crowns	50% Covered Benefit 1 in 60 months on same tooth-not a benefit under age 12	45% Covered	40% Covered Benefit 1 in 60 months on same tooth-not a benefit under age 12	Not Covered
Dentures, Partials, Bridges	50% Covered Benefit 1 in 60 months- not a benefit under age 16	45% Covered	40% Covered Benefit 1 in 60 months- not a benefit under age 16	Not Covered
Implants	50% Covered Benefit 1 in 60 months on the same tooth- not a benefit under age 12	45% Covered	Not a covered benefit on this dental plan	
ORTHODONTICS (Braces)				
Complete Orthodontic Evaluation.	60% Covered	50% Covered	50% Covered	Not Covered