# CSEBO DENTAL INSURANCE
## DELTA DENTAL PPO
## EFFECTIVE 1/1/2025 - 12/31/2025

| PLAN NAME | DELTA DENTAL PPO[1] | |
|---|---|---|
| GENERAL PLAN INFORMATION | DELTA DENTAL PPO PROVIDERS[1] | PREMIER & NON-DELTA DENTAL PPO PROVIDERS |
| **Calendar Year Annual Maximum** | | |
| | $2,500 | $2,500 |
| **Incentive Levels** | | |
| Percentage level increases 10% for each consecutive year the dentist is visited, to a maximum of 100%. | 70/80/90/100% | 70/80/90/100% |
| **Diagnostic and Preventive Benefits** | **Incentive Level Coverage** | |
| Prophylaxis (Cleaning) Treatments | Plan Pays 100%; limited to 2 per calendar year[2] | Plan Pays 100%; limited to 2 per calendar year[2] |
| Oral Examinations | Plan Pays 100%; limited to 2 per calendar year[2] | Plan Pays 100%; limited to 2 per calendar year[2] |
| Full-Mouth X-Rays | Plan Pays 100%; limited to 1 per 36 months[2] | Plan Pays 100%; limited to 1 per 36 months[2] |
| Bitewing X-Rays | Plan Pays 100%; upon provider request, maximum of 2 per calendar year[2] | Plan Pays 100%; upon provider request, maximum of 2 per calendar year[2] |
| Periodontal Scaling and Root Planing | Plan Pays 100%; limited to 1 each quadrant every 24 months | Plan Pays 100%; limited to 1 each quadrant every 24 months |
| Fluoride Treatments | Plan Pays 100% limited to 4 per calendar year.[2] | Plan Pays 100% limited to 4 per calendar year.[2] |
| Space Maintainers | Plan Pays 100%[2] | Plan Pays 100%[2] |
| **Basic Benefits** | **Incentive Level Coverage** | |
| Oral Surgery - Extractions | Plan Pays 70/80/90/100%; limited to once per tooth per lifetime | Plan Pays 70/80/90/100%; limited to once per tooth per lifetime |
| Oral Surgery - Other Surgical Procedures | Plan Pays 50-100% depending on procedure | Plan Pays 50-100% depending on procedure |

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| **Basic Benefits (continued)** | **Incentive Level Coverage** | |
| Restorative Procedures - Amalgam, Silicate or Composite (Resin) Restorations (Fillings) | Plan Pays 70/80/90/100%; limited to once per surface, per tooth within a 2 year period | Plan Pays 70/80/90/100%; limited to once per surface, per tooth within a 2 year period |
| Endodontic Treatments | Plan Pays 70/80/90/100%; limitations apply | Plan Pays 70/80/90/100%; limitations apply |
| Periodontic Treatment | Plan Pays 70/80/90/100%; limitations apply | Plan Pays 70/80/90/100%; limitations apply |
| Sealants | Plan Pays 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14. | Plan Pays 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14. |
| **Crowns, Inlays, Onlays and Cast Restoration Benefits** | **Incentive Level Coverage** | |
| Crowns, Inlays, Onlays and Cast Restoration | Plan Pays 70/80/90/100%; service on the same tooth only once every 5 years | Plan Pays 70/80/90/100%; service on the same tooth only once every 5 years |
| **Prosthodontic Benefits** | **Incentive Level Coverage** | |
| Implants | Plan Pays 50%; limited to once every 5 years | Plan Pays 50%; limited to once every 5 years |
| Removable - Partial Dentures, Full Dentures | Plan Pays 50%; limited to once every 5 years | Plan Pays 50%; limited to once every 5 years |
| Fixed - Inlays, Onlays, Bridges | Plan Pays 50%; limited to once every 5 years | Plan Pays 50%; limited to once every 5 years |
| **Nightguards** | **Incentive Level Coverage** | |
| Coverage Percentage | Plan Pays 100%; limited to once per lifetime | Plan Pays 100%; limited to once per lifetime |
| Lifetime Individual Maximum | $500 | $500 |
| **Orthodontia Benefits** | **Incentive Level Coverage** | |
| Coverage Eligibility | Not Covered | Not Covered |

[1]Reimbursement to providers is based on the PPO contracted fee for PPO dentists. Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

[2]2 cleanings, Exams and X-ray costs do not count towards the calendar year annual maximum.

Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

To access the Uniform Glossary of Health Coverage and Medical Terms, please visit: http://www.csebo.net/Resources/Uniform-Glossary.