MAPLETON PUBLIC SCHOOLS
July 1, 2025 - June 30, 2026
DENTAL INSURANCE RATES

This is only for illustrative and summary purposes. The contents of this summary are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted on the following pages. The benefits in this summary may only be available if required plan procedures are followed (e.g., use of specific providers or facilities).

Summary of Covered Benefits	Delta Dental – Plan B
Network	PPO, Premier or Non-Participating Dentist
Maximum Benefit	$1,500 per member per plan year
Deductible	$50 Individual / $150 Family
Diagnostic & Preventive: Cleaningm Exams, X-rays	Deductible Waived 100% Covered
Basic Services: Fillings, Simple Extractions, Oral Surgery, Endontics/Periodontics	Deductible Applies 80% Coinsurance
Major Services: Crowns, Impants, Dentures, Bridges	Deductible Applies 50% Coinsurance
Orthodontics: (for children to age 19 only)	Covered 50% $1,500 Lifetime Maximum
Coverage Tier	**Employee Cost Semi-Monthly**
Employee Only	$ 0.00
Employee + Spouse	$17.00
Employee _ Child(ren)	$28.50
Employee + Family	$44.00