



SUMMARY OF COVERAGE

Deductible

Individual

Family

Annual Benefit Maximum

per person per calendar year

Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
\$25*	\$50*	\$50*
\$75*	\$150*	\$150*
\$2,000		

BENEFIT CATEGORIES

Diagnostic & Preventive Services

routine check-ups, teeth cleaning, bitewing x-rays, full mouth x-rays, fluoride

Routine & Restorative Services

cavity repair, tooth extractions, general anesthesia/sedation, routine oral surgery, emergency treatment

Posterior Composites

silver filling on back teeth**

Endodontic Services

root canals and therapy

Periodontal Services

non-surgical procedures, gum and bone diseases, surgical procedures, perio maintenance therapy

High Cost Restorations

repair crowns, crowns, recementing crowns

Prosthetics

bridges, dentures, repairs and adjustments

Corrective Orthodontia Benefit & Lifetime Maximum

Child Only

Coinsurance paid by member

Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
0%	10%	10%
30%	30%	30%
30%	30%	30%
50%	50%	50%
50%	50%	50%
50%	50%	50%
50%	50%	50%
50% coinsurance and \$1,500 lifetime maximum.		

*Deductible is waived for diagnostic and preventive care.

Orthodontia benefits for eligible children to age 19 and full-time students eligible to age 19.

**If you choose a tooth-colored filling for your back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.

Percentages shown are what the member pays. Eligible children to age 26. Full-time (unmarried) students eligible to age 99.

The information on this page summarizes your benefits. This is a general description of your benefits. If you do not see a service listed, please see your benefits document for a full description of coverage.