DELTA DENTAL®

DUAL OPTION PLAN

SUMMARY OF COVERAGE	LOW			HIGH		
	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
Deductible per person	$25*	$50*	$75*	$15*	$25*	$50*
Annual Benefit Maximum per person per calendar year	$1,000			$2,000		
BENEFIT CATEGORIES	Coinsurance paid by member					
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0%	0%	20%	0%	0%	20%
Routine & Restorative Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	40%	50%	60%	20%	30%	50%
Posterior Composites (without alternate processing)	50%	60%	70%	40%	50%	60%
Endodontic Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)	50%	60%	70%	40%	50%	60%
Periodontal Services (gum and bone diseases, complex procedures)	50%	60%	70%	40%	50%	60%
High Cost Restorations (cast restorations – crowns, inlays, onlays, posts, cores)	50%	60%	70%	50%	60%	70%
Prosthetics (bridges, dentures)	50%	60%	70%	50%	60%	70%
Implants	60%	60%	70%	50%	50%	70%
Corrective Orthodontia Benefit & Lifetime Maximum up to age 19	Not Covered			50% coinsurance and $1,500 lifetime maximum		
Enhanced Benefits (extra dental benefits based on medical conditions)	Not Included			Not Included		
To Go℠ (carry over unused benefits)	Not Included			Not Included		

* Deductible is waived for all diagnostic and preventive care services.

The information on this page summarizes your benefits and payment obligations. This is a general description of your benefits. Please see your benefits document for a full description of coverage.