DELTA DENTAL®

ESSENTIAL PLAN

SUMMARY OF COVERAGE	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
Deductible per person	$50*	$75*	$100*
Annual Benefit Maximum per person per calendar year	$1,000		
BENEFIT CATEGORIES	Coinsurance paid by member		
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	10%	20%	30%
Routine & Restorative Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	40%	50%	60%
Posterior Composites (without alternate processing)	50%	60%	70%
Endodontic Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)	50%	60%	70%
Periodontal Services (gum and bone diseases, complex procedures)	50%	60%	70%
High Cost Restorations (cast restorations – crowns, inlays, onlays, posts, cores)	60%	70%	70%
Prosthetics (bridges, dentures)	60%	70%	70%
Implants	60%	70%	70%
Enhanced Benefits Program (extra dental benefits based on medical conditions)	Pregnancy, high-risk cardiac conditions, suppressed immune systems, diabetes, periodontal disease, cancer, chemotherapy, radiation, and kidney failure or dialysis		
To Go℠	Carry over a portion of your unused Annual Benefit Maximum from one benefit period to the next**		

* Deductible is waived for all diagnostic and preventive care services.
** The To Go Annual Maximum Carryover amount cannot exceed the Annual Benefit Maximum.

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.