

PRESTIGE PLAN

SUMMARY OF COVERAGE

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
Individual/Family Deductible per calendar year	\$50* / \$150*	\$50* / \$150*	\$50* / \$150*
Annual Benefit Maximum per person per calendar year	Unlimited	\$1,500	\$1,000

BENEFIT CATEGORIES

Coinsurance paid by member

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0%	0%	10%
Routine & Restorative Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	10%	20%	30%
Posterior Composites (tooth-colored filling on back teeth)	10%	20%	30%
Endodontic Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)	10%	20%	30%
Periodontal Services (gum and bone diseases, complex procedures)	10%	20%	30%
High Cost Restorations (cast restorations – crowns, inlays, onlays, posts, cores)	40%	50%	50%
Prosthetics (bridges, dentures)	40%	50%	50%
Implants	40%	50%	50%
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		
CheckUp PlusSM	Diagnostic and preventive dental service costs are waived from a Covered Person's Benefits Period Maximum		

* Deductible is waived for all diagnostic and preventive care.

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.