SUMMARY OF COVERAGE	HIGH PLAN		LOW PLAN	
	Delta Dental PPO™	Delta Dental Premier® / Non Par	Delta Dental PPO™	Delta Dental Premier® / Non Par
Deductible				
Individual	$15*	$25*	$25*	$50*
Family	$45*	$75*	$75*	$150*
Annual Period Maximum per person per calendar year	$1,500		$1,000	
BENEFIT CATEGORIES	Coinsurance paid by member			
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, periodontal maintenance therapy)	0%	0%	0%	0%
Routine & Restorative Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	10%	20%	40%	50%
Posterior Composites (tooth-colored filling on back teeth with alternative processing)	10%	20%	40%	50%
Endodontic Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)	50%	50%	50%	50%
Periodontal Services (gum and bone diseases, complex procedures, athletic mouth guards)	50%	50%	50%	50%
High Cost Restorations (cast restorations – crowns, inlays, onlays, posts, cores)	50%	50%	50%	50%
Prosthetics (bridges, dentures)	50%	50%	50%	50%
Implants	60%	60%	Not Covered	
Corrective Orthodontia Benefit & Lifetime Maximum up to age 19	50% coinsurance and $1,000 lifetime maximum		Not Covered	

MONTHLY RATES	High Option	Low Option
Single	$37.96	$34.12
Employee / Spouse	$70.98	$64.24
Employee / Child(ren)	$85.74	$75.92
Family	$139.02	$123.66

Eligible children through age 25. Full-time (unmarried) students eligible through age 99. Percentages shown are what the member pays.
*Deductible is waived for all diagnostic and preventive care.

Dental plans and rates are effective January 1, 2025 through December 31, 2025. 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.