

Plan Year 7/1/2020 – 6/30/2021

**Delta Dental PPO<sup>SM</sup> + PREMIER Network**

<b>PLAN YEAR MAXIMUM BENEFIT</b>			\$1,250 per person - Combination of in and out-of-network	
<b>PLAN YEAR DEDUCTIBLE</b> Applies to Basic and Major Services			<b>Per Person Deductible:</b> \$25 (Combination of in and out-of-network) There is no family deductible limit. Deductible will not be taken on services for children to age 13	
PPO	Premier	Non-Par	<b>COVERED SERVICES</b>	<b>BENEFIT INFORMATION</b> (subject to Delta Dental guidelines)
<b>MEMBER COST</b>				
<b>PREVENTIVE AND DIAGNOSTIC SERVICES - Preventive and Diagnostic services do not apply to Plan year Maximum</b>				
0%	20%	20%	Oral Evaluation	Limited to 2 evaluations in a plan year.
			Bitewing X-rays	Limited to 2 sets in a plan year.
			Full Mouth or Panoramic X-rays	Limited to 1 in a 36 month period.
			Routine Cleaning	Limited to 4 cleanings in a plan year.
			Fluoride Treatments	Limited to 2 treatments in a plan year under age 17.
			Space Maintainers	For premature loss of baby back teeth only under age 16.
			Sealants	1 per tooth in 36 months under age 17 on unrestored permanent molars.
<b>BASIC SERVICES - Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions)</b>				
50%	50%	50%	Amalgam, Resin and Composite Fillings	Benefit on the same surface limited to 1 in 12 months.
50%	50%	50%	Oral Surgery (Extractions)	
			General Anesthesia	Benefit with covered oral surgery only.
			Surgical Periodontal (gums)	Benefit once per quadrant every 36 months.
			Root Canal Therapy	Benefit once per tooth.
<b>MAJOR SERVICES - Crowns, Bridges, Partials, Dentures, Implants</b>				
50%	50%	50%	Crowns	Benefit 1 per tooth in 60 months on same tooth. Not a benefit under age 12.
			Dentures, Partials, Bridges	Benefit 1 in 60 months. Not a benefit under age 16.
			Bridge/Denture Repair	Benefit after 6 months from insertion.
			Denture Rebase/Reline	Benefit 6 months after initial insertion then benefit 1 in 36 months.
			Implants	Benefit 1 per tooth in 60 months on same tooth.

**The PPO percentage of benefits is based on the PPO Schedule of Allowances.**

**The Premier percentage of benefits is limited to the Premier Maximum Plan Allowance.**

**The non-participating percentage of benefits is limited to the non-participating Maximum Plan Allowance. You will be responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the dentist.**

**Right Start 4 Kids:** Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier provider to receive the 100% coinsurance. If an out-of-network provider is seen, the adult coinsurance levels will apply.

**Important Note:** This form provides only a brief description of services covered under your contract and does not list those services which are limited or excluded from coverage. Your Summary Plan Description provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this Summary of Benefits and your Summary Plan Description, the Summary Plan Description will govern.