Delta Dental PPO℠

High Plan

HIGH PLAN BENEFITS	PPO Network	Non - PPO Network**
ANNUAL CALENDAR YEAR DEDUCTIBLE		
Deductible applies to:	$50/ person $150/ family (type B,C)	$50/ person $150/ family (type A, B, C)
ANNUAL CALENDAR YEAR MAXIMUM		
Maximum benefit allowed per person for Types A, B & C Combined	$1,500	$1,500
PREVENTIVE (Type A)	**Plan Pays**	**Plan Pays**
X-rays (bitewing 2 per year)	100%	100% **
X-rays (full mouth or panoramic every 3 years)	100%	100% **
Cleaning and scaling (2 per year)	100%	100% **
Fluoride treatment (up to age 19 - two per year)	100%	100% **
Space maintainers - unilateral (up to age 19)	100%	100% **
Sealants (Dependent child up to age 19 - once every 2 years on permanent molars only)	100%	100% **
BASIC SERVICE (Type B)		
Amalgams (2 surfaces)	80%*	80% **
Periodontics maintenance (4 per calendar year less regular cleanings)	80%*	80% **
MAJOR SERVICE (Type C)		
Denture relining (chairside)	50% *	50% **
Denture adjustments	50% *	50% **
General anesthesia (30 minutes)	50% *	50% **
Impacted teeth	50% *	50% **
Periodontics (gum treatment) scaling and root planing	50% *	50% **
Crowns	50% *	50% **
Bridges	50% *	50% **
Full dentures	50% *	50% **
Partial dentures	50% *	50% **
Resin base Inlays	50% *	50% **
Onlays	50% *	50% **
Simple extractions	50% *	50% **
Additional extraction	50% *	50% **
Surgical extractions	50% *	50% **
Root canal therapy Anterior	50% *	50% **
Bicuspid	50% *	50% **
Molar	50% *	50% **
Repairs to prosthetics	50% *	50% **
ORTHODONTIA (Type D)		
Amount	50%* $1500/person	50% ** $1500/person

* PPO Network: Member pays balance after plan pays.

** Non - PPO Network: Member pays balance in addition to the remaining balance of claim. Balance equals the difference between total claim and PPO fee.

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.