Delta Dental PPO℠

Standard Plan

STANDARD PLAN BENEFITS	PPO Network	Non - PPO Network**
ANNUAL CALENDAR YEAR DEDUCTIBLE		
Deductible applies to:	None	$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)	**Employee Pays**	**Plan Pays**
X-rays (bitewing 2 per year)	$0	90% **
X-rays (full mouth or panoramic every 3 years)	$0	90% **
Cleaning and scaling (2 per year)	$15	90% **
Fluoride treatment (up to age 19 - two per year)	$0	90% **
BASIC SERVICE (Type B)		
Space Maintainers - unilateral (up to age 19)	$105	60% **
Sealants (Dependent child up to age 19 - once every 2 years on permanent molars only)	$15	60% **
Amalgams (2 surfaces)	$45	60% **
Periodontics maintenance (4 per calendar year less regular cleanings)	$40	60% **
MAJOR SERVICE (Type C)		
Denture relining (chairside)	$105	30% **
Denture adjustments	$30	30% **
General anesthesia (30 minutes)	$155	30% **
Impacted Teeth	$145	30% **
Periodontics (gum treatment) scaling and root planing	$85 per quad	30% **
Crowns	$475	30% **
Bridges	$435	30% **
Full dentures	$535	30% **
Partial dentures	$420	30% **
Resin base Inlays	$330	30% **
Onlays	$475	30% **
Simple extractions	$50	30% **
Additional extraction	$50	30% **
Surgical extractions	$105	30% **
Root canal therapy		
Anterior	$300	30% **
Bicuspid	$355	30% **
Molar	$490	30% **
Repairs to prosthetics	$80	30% **
ORTHODONTIA (Type D)		
Amount	$2,100	50% ** $1500/person

** 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.