

# DELTA Dental Plan

	DELTA	
<b>Choice of Dentist</b>	Choose any dentist you wish for services and receive applicable benefits. Save the most with a Delta Dental PPO network participating dentist. Percentages below are based on Delta's applicable allowances and not the dentist's actual charge. Payments to non preferred providers are based on Reasonable and Customary (not billed) charges.	
<b>Maximum Benefit/Deductible</b>	\$1,000 per year per person \$50 deductible per year per person; \$150 family maximum	\$1,500 per year per person \$50 deductible per year per person; \$150 family maximum
<b>Type I</b>	<b>STANDARD Plan Pays</b> (No deductible)	<b>ENRICHED Plan Pays</b> (No deductible)
0150 Comprehensive Oral Evaluation -New or Established	100%	100%
0120 Periodic Oral Exam	100%	100%
X-rays	100%	100%
1110/20 Prophylaxis	100% (Twice per calendar year)	100% (Twice per calendar year)
1203 Fluoride Treatment (children up to the age 19)	100%, 2x per year	100%, 2x per year
1351 Sealant - per tooth	100% to age 16	100% to age 16
1510 Space Maintainers	100% to age 19	100% to age 19
<b>Type II</b>	*	*
Fillings: (resin)		
2330 one surface	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP
2331 two surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP
2332 three surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP
2335 four or more surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP
Root canals:		
3310 Anterior	75%	75%
3320 Bicuspid	75%	75%
3330 Molar	75%	75%
3410 Apicoectomy	75%	75%
Extractions:		
7111 Single tooth	75%	75%
7140 Extraction, erupted tooth or exposed tooth	75%	75%
7210 Surgical extraction of erupted tooth	75%	75%
Periodontics: (gum treatment)		
4341 Periodontal scaling & root planning-per quadrant	75%	75%
4210 Gingivectomy/gingivoplasty - per quadrant	75%	75%
4910 Periodontal maintenance procedures	75%	75%
<b>Type III</b>	*	*
Crown & Bridge		
2930 Prefabricated stainless steel primary tooth	50%	50%
2791 Crown full cast predominately base metal	50%	50%
2751 Crown Porcelain fused to base metal	50%	50%
Pontics:		
6210 Full cast	50%	50%
6240 Porcelain fused to metal	50%	50%
Prostodontics (Dentures)		
5110 Complete upper	50%	50%
5120 Complete lower	50%	50%
5213/14 Partial upper or lower - cast metal base	50%	50%
<b>ORTHODONTIA</b>		
Consultation	Not Covered	Adult & Children covered at 50% after a one time deductible of \$50 per person. \$1,000 lifetime maximum
Evaluation	Not Covered	
Records	Not Covered	
Children - Normal Class II	Not Covered	
Adult - Normal Class II	Not Covered	
8750 Retention	Not Covered	
<b>VISION</b>		
Examination	Not Covered	Not Covered
Single Vision Lenses	Not Covered	Not Covered
Bifocal Lenses	Not Covered	Not Covered
Trifocal Lenses	Not Covered	Not Covered
Contact Lenses - Non-Elective	Not Covered	Not Covered
Contact Lenses - Elective	Not Covered	Not Covered
Frames	Not Covered	Not Covered

\* All Type II and III charges subject to annual deductible

\* The above reimbursements are exclusive of gold.