

	<u>Delta Dental PPO</u>	<u>Delta Dental Premier</u>	<u>Out of Network</u>
Annual Maximums	\$1,200.00	\$1,200.00	\$1,200.00
Annual Deductibles	None	None	None
Lifetime Maximums	None	None	None
Lifetime Deductibles	None	None	None
Ortho Annual Maximums	\$750.00	\$750.00	\$750.00
Ortho Annual Deductibles	None	None	None
Ortho Lifetime Maximums	\$2,000.00	\$2,000.00	\$2,000.00
Ortho Lifetime Deductibles	None	None	None
Custom Annual Maximums	None	None	None
Custom Annual Deductibles	None	None	None
Custom Lifetime Maximums	None	None	None
Custom Lifetime Deductibles	None	None	None
Annual Family Maximums	None	None	None
Annual Family Deductibles	None	None	None
Lifetime Family Maximums	None	None	None
Lifetime Family Deductibles	None	None	None
Annual Out-of-Pocket Maximum	None	None	None
Annual Family Out-of-Pocket Maximum	None	None	None

<u>Services</u> (Sample code displayed)	<u>Delta Dental PPO</u>		<u>Delta Dental Premier</u>		<u>Out of Network</u>	
	<u>Benefit Level</u>	<u>Deductible Applies</u>	<u>Benefit Level</u>	<u>Deductible Applies</u>	<u>Benefit Level</u>	<u>Deductible Applies</u>
Diagnostic D0150	100%	No	100%	No	100%	No
Pre-Diag D0431	None	No	None	No	None	No
Preventive D1110	100%	No	100%	No	100%	No
Sealants D1351	50%	No	50%	No	50%	No
Basic Restor D2140	80%	No	80%	No	80%	No
Inlays D2630	50%	No	50%	No	50%	No
Onlays D2643	50%	No	50%	No	50%	No
Major Restor D2750	50%	No	50%	No	50%	No
Core Buildup D2950	50%	No	50%	No	50%	No
Post/Core D2954	50%	No	50%	No	50%	No
Endodontics D3320	80%	No	80%	No	80%	No
Surg Perio D4260	None	No	None	No	None	No
Periodontics D4341	80%	No	80%	No	80%	No
Antimicrobial D4381	None	No	None	No	None	No
Perio Maint D4910	80%	No	80%	No	80%	No
Rmvbl Prosth D5110	50%	No	50%	No	50%	No
Prosth Repair D5670	80%	No	80%	No	80%	No
Prosth (Reb) D5710	80%	No	80%	No	80%	No
Prosth (Rel) D5730	80%	No	80%	No	80%	No
Surg Implants D6010	50%	No	50%	No	50%	No
Implants D6059	50%	No	50%	No	50%	No
Fixed Prosth D6750	50%	No	50%	No	50%	No

Simple Extract D7140	80%	No	80%	No	80%	No
Oral Surgery D7240	None	No	None	No	None	No
Brush Biopsy D7288	None	No	None	No	None	No
Orthodontics D8010	50%	No	50%	No	50%	No
Palliative D9110	100%	No	100%	No	100%	No
Nitrous Oxide D9230	80%	No	80%	No	80%	No
Gen Anesth D9241	80%	No	80%	No	80%	No
Ther Drug Inj D9610	80%	No	80%	No	80%	No
Desensitize D9910	None	No	None	No	None	No
Occl Guard D9940	None	No	None	No	None	No

<b>Services</b>	<b>Frequency and Other Benefit Limitations</b>	<b>Age Limitations</b>
Which Procedures Require Predetermination?	Predetermination of benefit is not required; however, it is highly recommended.	None
Initial/Periodic Exam		None
Full Mouth or Panoramic X-rays	Allowed at 3 year intervals	None
Bitewing X-rays	Allowed at 6 month intervals	None
Child Cleaning	Allowed 1 on same day.	13
Adult Cleaning	Allowed 1 on same day.	14 and Older
Fluoride	Allowed 1 in 12 months	17
Sealants	Generally limited to one placement per tooth on permanent unrestored 1st and 2nd molars without cavities.	18
Resin (White) Fillings	Alternate amalgam (silver) benefit on back teeth.	None
Periodontal Maintenance	Periodontal maintenance OR regular adult prophylaxis	None
Periodontal Scaling	Allowed at 24 month intervals.	None
Periodontal Surgery	Procedure not covered.	
Full Mouth Debridement	Allowed at 1 per lifetime.	None
Single Cast Restorations	Allowed at 5 year intervals.	12 and Older
Inlays (D2630) and Onlays (D2643)	Allowed at 5 year intervals. An alternate benefit generally applies.	12 and Older
Is Porcelain Covered on Posterior Teeth?	Allowed at 5 year intervals.	12 and Older
Prosthodontics	Allowed at 5 year intervals.	16 and Older
Is benefit for prosthodontic appliances available if the tooth was removed prior to coverage?	Yes. Predetermination is recommended. May be subject to consultant review.	16 and Older