DENTAL PLANS | Summary Of Benefits

	DELTA DENTAL PPO		DELTA DENTAL HMO-TYPE PLAN
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Calendar Year Maximum Benefit	$2,000 per person	$2,000 per person	No maximum
Calendar Year Deductible	$60 per person (does not apply to Type A services)	$60 per person (does not apply to Type A services)	$0
Type A Covered Services: Preventive and Diagnostic Services	100% of the network dentist contracted amount (subject to frequency limits)	100% of reasonable and customary charge	Most preventive services covered with no copay, most other services have copays, see benefit schedule for details*
Type B Covered Services: Basic and Restorative Services	70% of the network dentist contracted amount after deductible	70% of reasonable and customary charge after deductible	Amalgam fillings covered with no copays, most other services have copays, see benefit schedule for details*
Type C Covered Services: Major Restorative Services	50% of the network dentist contracted amount after deductible	50% of reasonable and customary charge after deductible	Most services have copays, see benefit schedule for details*
Dentures Repairs and Adjustments Initial Installation (Full or Partial) Replacement Limit	 Covered as Type B Covered as Type C Once every 60 mos.	 Covered as Type B Covered as Type C Once every 60 mos	Services have copays, see benefit schedule for details* Once every 60 months
Orthodontic Services Lifetime Maximum	50% of the network dentist contracted amount after deductible $2,500	50% of reasonable and customary charge after deductible $2,500	Services have copays, see benefit schedule for details* Maximum benefit period of 24 months
Teeth Whitening	Not Covered	Not Covered	Services have copays

*Delta Dental HMO-type Plan does not cover services provided by out-of-network dental providers.