CSEBO DENTAL INSURANCE
DELTA DENTAL COMPARISON
EFFECTIVE 10/1/2019 – 9/30/2020

DELTA DENTAL

PLAN NAME GENERAL PLAN INFORMATION	DELTA DENTAL HMO[1] IN-NETWORK ONLY	DELTA DENTAL PPO[2] IN-NETWORK	 OUT-OF-NETWORK
Calendar Year Annual Maximum			
	N/A	$1,700	$1,500
Incentive Levels			
Percentage level increases 10% for each consecutive year the dentist is visited, to a maximum of 100%.	N/A	70/80/90/100%	70/80/90/100%
Diagnostic and Preventive Benefits	**Applicable Copay**	**Incentive Level Coverage**	
Prophylaxis (Cleaning) Treatments	No cost per 6-month period, limited to 2 cleanings per calendar year	70/80/90/100%; limited to 2 per calendar year	70/80/90/100%; limited to 2 per calendar year
Oral Examinations	No cost	70/80/90/100%; limited to 2 per calendar year	70/80/90/100%; limited to 2 per calendar year
Full-Mouth X-Rays	No cost; limited to 1 series every 24 months	70/80/90/100%; limited to 1 per 36 months	70/80/90/100%; limited to 1 per 36 months
Bitewing X-Rays	No cost; limited to 1 series every 6 months	70/80/90/100%; upon provider request, maximum of 2 per calendar year	70/80/90/100%; upon provider request, maximum of 2 per calendar year
Periodontal Scaling and Root Planing	$20-$25; limited to 4 quadrants every 12 months	70/80/90/100%; limited to 1 each quadrant every 24 months	70/80/90/100%; limited to 1 each quadrant every 24 months
Fluoride Treatments	No cost to age 19 per 6-month period	70/80/90/100% limited to 2 per calendar year.	70/80/90/100% limited to 2 per calendar year.
Space Maintainers	$25	70/80/90/100%	70/80/90/100%
Basic Benefits	**Applicable Copay**	**Incentive Level Coverage**	
Oral Surgery - Extractions	No cost to $25 depending on procedure	70/80/90/100%	70/80/90/100%
Oral Surgery - Other Surgical Procedures	No cost to $110 depending on procedure	50-100% depending on procedure	50-100% depending on procedure
Restorative Procedures - Amalgam, Silicate or Composite (Resin) Restorations (Fillings)	No cost to $85 depending on procedure	70/80/90/100%	70/80/90/100%
Endodontic Treatments	No cost to $280 depending on procedure	70/80/90/100%	70/80/90/100%

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Basic Benefits (continued)	**Applicable Copay**	**Incentive Level Coverage**	
Periodontic Treatment	No cost to $280 depending on procedure	70/80/90/100%	70/80/90/100%
Sealants	$10 per tooth; limited to permanent molars up to age 15	70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.	70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.
Crowns, Inlays, Onlays and Cast Restoration Benefits	**Applicable Copay**	**Incentive Level Coverage**	
Crowns, Inlays, Onlays and Cast Restoration	No cost to $240 depending on procedure	70/80/90/100%; service on the same tooth only once every 5 years	70/80/90/100%; service on the same tooth only once every 5 years
Prosthodontic Benefits	**Applicable Copay**	**Incentive Level Coverage**	
Removable - Partial Dentures, Full Dentures	$120-$210 depending on denture; limited to once every 5 years	70%; limited to once every 5 years	50%; limited to once every 5 years
Fixed - Inlays, Onlays, Bridges	$40-$240 depending on denture; limited to once every 5 years	70%; limited to once every 5 years	50%; limited to once every 5 years
Orthodontia Benefits	**Applicable Copay**	**Incentive Level Coverage**	
Limited Orthodontic Treatment	$950-$1,150; based on age	Not covered	Not covered
Interceptive Orthodontic Treatment	$950	Not covered	Not covered
Comprehensive Orthodontic Treatment	$1,700-$1,900; based on age	Not covered	Not covered

[1]Each enrollee in the Delta Dental HMO must go to his or her assigned contract dentist to obtain covered services, except for services provided by a specialist preauthorized in writing by Delta Dental, or for emergency services as provided in the Evidence of Coverage (EOC) section, *Emergency Services* . Any other treatment is not covered under this program.

[2]Reimbursement to providers is based on the PPO contracted fee for PPO dentists. Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

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