CSEBO DENTAL INSURANCE
DELTA DENTAL COMPARISON
EFFECTIVE 1/1/2024 - 12/31/2024

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	$2,500	$2,500
Incentive Levels			
Percentage level increases 10% for each consecutive year the dentist is visited, to a maximum of 100%.	N/A	Plan pays: 70/80/90/100%	Plan pays: 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	Plan pays 100%; limited to 2 per calendar year[3]	Plan pays 100%; limited to 2 per calendar year[3]
Oral Examinations	No cost	Plan pays 100%; limited to 2 per calendar year[3]	Plan pays 100%; limited to 2 per calendar year[3]
Full-Mouth X-Rays	No cost; limited to 1 series every 24 months	Plan pays 100%; limited to 1 per 36 months[3]	Plan pays 100%; limited to 1 per 36 months[3]
Bitewing X-Rays	No cost; limited to 1 series every 6 months	Plan pays 100%; upon provider request, maximum of 2 per calendar year[3]	Plan pays 100%; upon provider request, maximum of 2 per calendar year[3]
Periodontal Scaling and Root Planing	$20-$25; limited to 4 quadrants every 12 months	Plan pays 100%; limited to 1 each quadrant every 24 months	Plan pays 100%; limited to 1 each quadrant every 24 months
Fluoride Treatments	No cost to age 19 per 6-month period	Plan pays 100% limited to 2 per calendar year.[3]	Plan pays 100% limited to 2 per calendar year.[3]
Space Maintainers	$25	Plan pays 100%[3]	Plan pays 100%[3]
Basic Benefits	**Applicable Copay**	**Incentive Level Coverage**	
Oral Surgery - Extractions	No cost to $25 depending on procedure	Plan pays: 70/80/90/100%	Plan pays: 70/80/90/100%
Oral Surgery - Other Surgical Procedures	No cost to $110 depending on procedure	Plan pays: 50-100% depending on procedure	Plan pays: 50-100% depending on procedure
Restorative Procedures - Amalgam, Silicate or Composite (Resin) Restorations (Fillings)	No cost to $85 depending on procedure	Plan pays: 70/80/90/100%	Plan pays: 70/80/90/100%

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Basic Benefits (continued)	**Applicable Copay**	**Incentive Level Coverage**	
Endodontic Treatments	No cost to $280 depending on procedure	Plan pays: 70/80/90/100%	Plan pays: 70/80/90/100%
Periodontic Treatment	No cost to $280 depending on procedure	Plan pays: 70/80/90/100%	Plan pays: 70/80/90/100%
Sealants	$10 per tooth; limited to permanent molars up to age 15	Plan pays: 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.	Plan pays: 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	Plan pays: 70/80/90/100%; service on the same tooth only once every 5 years	Plan pays: 70/80/90/100%; service on the same tooth only once every 5 years
Prosthodontic Benefits	**Applicable Copay**	**Incentive Level Coverage**	
Implants	Not covered	Plan pays: 70%; limited to once every 5 years	Plan pays: 50%; limited to once every 5 years
Removable - Partial Dentures, Full Dentures	$120-$210 depending on denture; limited to once every 5 years	Plan pays: 70%; limited to once every 5 years	Plan pays: 50%; limited to once every 5 years
Fixed - Inlays, Onlays, Bridges	$40-$240 depending on denture; limited to once every 5 years	Plan pays: 70%; limited to once every 5 years	Plan pays: 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.

[3]2 cleanings, exams and x-ray costs do not count towards the calendar year annual maximum.

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.