

YOUR DELTA DENTAL PLAN INCLUDES ALL OF THE FOLLOWING SERVICES			
Type	Diagnostic & Preventive (Referred to as Coverage A)	Basic Restorative (Referred to as Coverage B)	Major Restorative (Referred to as Coverage C)
Covered Services	<p><b>DIAGNOSTIC:</b> Evaluations once in a 6-month period</p> <p>X-rays (complete series or panoramic film) once in a 3-year period</p> <p>Bitewing x-rays once in a 12-month period</p> <p>X-rays of individual teeth as necessary</p> <p><b>PREVENTIVE:</b> Cleanings once in a 6-month period</p> <p>Fluoride once in a 12-month period to age 19</p> <p>Space maintainers to age 16</p> <p>Sealant application to permanent molars, once in a lifetime per tooth, for children to age 15</p>	<p><b>RESTORATIVE:</b> Fillings Amalgam (silver) Composite (white)</p> <p><b>ORAL SURGERY:</b> Surgical and routine extractions</p> <p><b>ENDODONTICS:</b> Root canal therapy</p> <p><b>PERIODONTICS:</b> Treatment of gum disease Periodontal cleaning (maintenance procedures)</p> <p><b>DENTURE REPAIR:</b> Repair of removable denture to its original condition Rebase and reline</p> <p><b>EMERGENCY PALLIATIVE TREATMENT</b></p> <p><b>Note:</b> <i>Only one cleaning is covered in a 6-month period. This can be routine (Coverage A) or periodontal (Coverage B), but not both.</i></p>	<p><b>PROSTHODONTICS:</b> Removable and fixed partial dentures (bridges); complete dentures</p> <p>Crowns</p> <p>Onlays</p>
Deductible	No Deductible	Contract Year Deductible (January 1 through December 31): \$50 Per Person, up to a Maximum of \$150 Per Family	
Coinsurance	Delta Dental Pays 100%	After Deductible, Delta Dental Pays 80%	After Deductible, Delta Dental Pays 50%
Maximum	Coverage A, B and C <u>Combined</u> Contract Year Maximum (January 1 through December 31): \$1,250 Per Person		

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THIS FLOWCHART IS FOR ILLUSTRATIVE PURPOSES ONLY. CERTAIN BENEFIT LIMITATIONS MAY APPLY. PLEASE REFER TO YOUR DENTAL PLAN DESCRIPTION BOOKLET FOR COMPLETE BENEFIT INFORMATION.

**EXCEPTIONAL SERVICE IS OUR GUARANTEE**