DELTA DENTAL

Dental Benefits Summary

Curators of the University of MO BUY UP PLAN	Delta Dental PPO℠ Network	Delta Dental Premier® Network	Out-of-Network
	Based on applicable PPO Maximum Plan Allowance - No balance billing	Based on applicable Premier Maximum Plan Allowance - No balance billing	Based on Fair Health 90th Percentile - Balance billing is possible
Preventive Services • Oral examinations, twice in any benefit period • Periapical x-rays, as required • Bitewing x-rays two sets per benefit period • Full-mouth x-rays once in any 36-month period • Dental prophylaxis (cleaning, scaling, and polishing), twice in any benefit period • Topical fluoride application for dependent children under age 19, twice in any benefit period • Emergency palliative treatment • Space maintainers - children under age 19 • Sealants: under age 16, limited to caries-free teeth	**100%**	**100%**	**100%**
Basic Services • Fillings, including composite fillings on all teeth • Periodontics • Periodontal maintenance, four in any benefit period • Endodontic • Simple and surgical extractions • General anesthesia • Repair or re-cementing of crowns, inlays, onlays, dentures, or bridgework • Denture adjustments, repairs, rebase and relines to complete and partial dentures. Denture relines and rebases - once in 36 months • Implants, as well as bone grafts • Oral surgery, excluding repairs of jaw fractures • Brush biopsy	**80%**	**80%**	**80%**
Major Services • Prosthetics: bridges and dentures, once in 5 years • Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes and when teeth cannot be restored with a filling material, as required	**50%**	**50%**	**50%**
Orthodontia • Orthodontia for all eligible participants (lifetime maximum)	**50% up to $1,500 No deductible**	**50% up to $1,500 No deductible**	**50% up to $1,500 No deductible**
Calendar Year Deductible (Applies to Basic and Major services)	**$50 individual 3X family**	**$50 individual 3X family**	**$50 individual 3X family**
Annual Maximum (Applied to Preventive, Basic, and Major services)	**$2,000**	**$2,000**	**$2,000**
Dependent Age Limit: 26			

This is intended to be a summary only. If a discrepancy occurs the Summary Plan Document will govern. Please refer to your Summary Plan Description (SPD) for a more complete listing of services including plan limitations and exclusions. Orthodontic treatment in progress may be covered. Benefits provided by the prior carrier will be subtracted from the lifetime maximum available from Delta Dental.