DELTA DENTAL

ISEBA — VOLUNTARY TRUST

SUMMARY OF COVERAGE

	PLAN B		
	PPO™	Premier®	Out-of-Network
Deductible			
Individual	$50*	$50*	$75*
Annual Period Maximum per person per calendar year	$1,000		

BENEFIT CATEGORIES

	Coinsurance paid by member		
Diagnostic & Preventive Services** (check-ups, teeth cleaning, x-rays, space maintainers, sealant applications, flouride)	0%	0%	20%
Routine & Restorative Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	10%	20%	40%
Posterior Composites (tooth-colored filling on back teeth without alternative processing)	40%	50%	60%
Endodontic Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings, pulpotomy)	40%	50%	60%
Periodontal Services (gum and bone diseases, complex procedures)	40%	50%	60%
High Cost Restorations (cast restorations - crowns, inlays, onlays, posts, cores)	50%	50%	60%
Prosthetics (bridges and dentures)	50%	50%	60%
Implants	60%	60%	70%
Orthodontic Services***	50%		
Enhanced Benefits Program Included	Yes		

MONTHLY RATES

	PLAN B
Single	$34.34
Employee / Spouse	$67.62
Employee / Child(ren)	$76.72
Family	$129.48

Eligible children through age 25. Full-time (unmarried) students eligible through age 99. Percentages shown are what the member pays.
*Deductible is waived for all diagnostic and preventive care.
**Fluoride applications through age 18. Sealants for Plans A and B through age 18, and Plan C through age 13.
***Plan B orthodontic lifetime maximum is $1,000. Dependents and full-time students eligible through age 18.

Dental plans and rates are effective July 1, 2023 through June 30, 2024. The information on this page summarizes your benefits and payment obligations. This is a general description of your benefiw s. Please see your benefits document for a full description of coverage.