

**Delta Dental of Missouri**  
**Shelf plan option 3**

	Delta Dental PPO™ network Based on applicable PPO maximum plan allowance – no balance billing	Delta Dental Premier® network Based on applicable Premier maximum plan allowance – no balance billing	Out of network Based on applicable maximum plan allowance for out- of- network dentist – balance billing is possible
<b>Preventive services</b> <ul style="list-style-type: none"> <li>• Bitewing x-rays, one set per benefit period</li> <li>• Full-mouth x-rays (pano), once in any 36-month period</li> <li>• Oral examinations, twice in any benefit period</li> <li>• Periapical x-rays, as required</li> <li>• Prophylaxis (cleanings), twice in any benefit period</li> <li>• Sealants for dependent children under age 16, once in any 36-month period</li> <li>• Topical fluoride treatments for dependent children under age 16, twice in any benefit period</li> </ul>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Basic services</b> <ul style="list-style-type: none"> <li>• Composite fillings on all teeth</li> <li>• Emergency palliative treatment</li> <li>• Fillings</li> <li>• Non-surgical periodontics</li> <li>• Periodontal maintenance, twice in any benefit period (subject to your prophylaxis frequency limitation)</li> <li>• Simple extractions</li> <li>• Space maintainers for dependent children under age 16, once in 5 years</li> </ul>	<b>80%</b>	<b>80%</b>	<b>80%</b>
<b>Major services</b> <ul style="list-style-type: none"> <li>• Bridges, once in 7 years</li> <li>• Crowns, inlays, onlays, once in 7 years</li> <li>• Dentures, once in 7 years</li> <li>• Endodontics</li> <li>• General anesthesia</li> <li>• Implants (as well as bone grafts) are a covered benefit, limited to once in 7 years</li> <li>• Oral surgery (excluding extractions)</li> <li>• Surgical extractions</li> <li>• Surgical periodontics</li> </ul>	<b>50%</b>	<b>50%</b>	<b>50%</b>
<b>Orthodontia</b> <ul style="list-style-type: none"> <li>• Not covered</li> </ul>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Calendar year deductible</b> (Applied to basic and major services)	<b>\$50 individual 3X family</b>	<b>\$50 individual 3X family</b>	<b>\$50 individual 3X family</b>
<b>Annual maximum</b> (Applied to preventive, basic and major services)	<b>\$2,000</b>	<b>\$2,000</b>	<b>\$2,000</b>
<b>Dependent age limit:</b> 26			
<b>Added features included:</b> Healthy Smiles, Healthy Lives® – two additional cleanings are covered per benefit period for patients who are pregnant, diabetic, have a suppressed immune system or have a history of periodontal therapy.			

*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. Benefits provided by the prior carrier will be subtracted from the lifetime maximum available from Delta Dental.*