DELTA DENTAL

Dental Benefits Summary

TRUMAN STATE UNIVERSITY PLAN B (7620-2000) Benefit Summary[1]	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 applicable Maximum Plan Allowance for Out-of-Network dentist - Balance billing is possible
Preventive Services • Oral examinations, twice in any benefit period • Prophylaxis (cleanings), twice in any benefit period • Periodontal maintenance, twice in any benefit period (subject to the prophylaxis frequency limitations) • Bitewing x-rays, one set per benefit period • Sealants for dependent children under age 16, once in any 5 year period • Space maintainers for dependent children under age 16, once in 5 years • Topical fluoride treatments for dependent children under age 14, once in any benefit period • Emergency palliative treatment	**100%**	**100%**	**100%**
Basic Services • Periapical x-rays as required • Full-mouth x-rays, once in any 36 month period • Fillings: amalgam (silver) on posterior teeth and composite (white) on anterior teeth • Simple extractions	**80%**	**80%**	**80%**
Major Services • Periodontics: treatment for diseases of the gums and bones supporting the teeth. Periodontal surgery is covered only once in a 3 year period for the same site. Coverage for root planing and scaling are limited to once per 24 months • Endodontics: root canal filing and pulpal therapy • Surgical extractions • Oral surgery • General anesthesia in conjunction with a covered surgical procedure • Crowns, bridges, dentures, inlays, onlays, once in 5 years	**50%**	**50%**	**50%**
Orthodontic Services • Orthodontia treatment that begins while covered on this plan (Plan B), for dependent children under age 19	**1st Benefit Period: N/A** **2nd Benefit Period: N/A** **3rd Benefit Period: 50%**	**1st Benefit Period: N/A** **2nd Benefit Period: N/A** **3rd Benefit Period: 50%**	**1st Benefit Period: N/A** **2nd Benefit Period: N/A** **3rd Benefit Period: 50%**
Calendar Year Deductible[2] (Applied to Basic & Major)	**$50 per person**		
Calendar Year Maximum[2] (Applied to Preventive, Basic, & Major)	**$1,000 per person**		
Lifetime Orthodontic Maximum	**$1,500 per eligible dependent**		
Dependent Age Limit: 26, end of calendar year			

[1] This is intended to be a summary only. Please refer to your Summary Plan Description (SPD) for a more complete listing of services, including plan limitations and exclusions. If a discrepancy occurs, the SPD will govern.

[2] **Effective January 1, 2027, the benefit period will reflect a calendar year. A new benefit period renews each January 1st.**