Type of Service	PPO Plus Premier		DeltaCare
	In-Network	Out-of-Network	In-Network Only
Calendar Year Deductible Individual/Family (AppliestoTypeB&CServicesOnly)	$50 / $150		None
Calendar Year Maximum	$2,000 per individual In & Out-of-Network amounts cross-apply		Unlimited
Type A - Preventative & Diagnostic			
Oral Exam	100%	100%	100%
Cleanings (Once every 6 months)	100%	100%	100%
Bitewing X-Rays	100%	100%	100%
Type B - Basic Services			
Fillings	80% after deductible	80% after deductible	100%
Periodontal Scaling	80% after deductible	80% after deductible	100%
Simple Extractions	80% after deductible	80% after deductible	100%
Type C - Major Restorative Care			
Crowns	50% after deductible	50% after deductible	Schedule of Benefits
Crown Repairs	50% after deductible	50% after deductible	Schedule of Benefits
Root Canal	50% after deductible	50% after deductible	Schedule of Benefits
Surgical Extraction	50% after deductible	50% after deductible	Schedule of Benefits
Bridges	50% after deductible	50% after deductible	Schedule of Benefits
Type D - Orthodontia			
Deductible	Not Applicable		Not Applicable
Orthodontia Treatment	50%		$2,000
Lifetime Maximum	$1,000		Not Applicable
Lifetime Maximum	Adults & Children		Adults & Children