

YOUR DENTAL BENEFITS

Prepared for the employees of Prevea Clinic, Inc

The summary below does not cover all plan details. Further information can be found in the Summary Plan Description or dental benefit handbook. That document provides a thorough explanation of your dental plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

	Basic Plan	Standard Plan	Plus Plan
	Delta Dental PPO™ Delta Dental Premier® or Out-of-Network**	Delta Dental PPO™ Delta Dental Premier® or Out-of-Network**	Delta Dental PPO™ Delta Dental Premier® or Out-of-Network**
Individual Annual Maximum	\$1,000	\$1,250	\$1,250
Deductible - Ind./Family	\$50/\$150	\$50/\$150	\$50/\$150
Diagnostic & Preventive Exams (2x/year) Cleanings (2x/year) Fluoride treatments (2x/year to age 19) X-rays (bitewings every 12 months & full mouth every 5 years) Space maintainers Sealants (once per tooth to age 19)	100%	100%	100%
Basic Services Emergency treatment to relieve pain Fillings (silver & composite) Root canals Treatment of gum disease Extractions (surgical & non-surgical) Repairs & adjustments to bridges & dentures	50%*	80%*	80%*
Major Services Crowns, inlays, onlays Bridges & dentures Implants	No coverage	No coverage	50%*
Orthodontic Services Coverage copayment Adults & dependents to age 26	No coverage	No coverage	50% \$1,000 Lifetime Maximum
EBICP***	Yes	Yes	Yes
Dependent Eligibility	Dependents are covered to age 26		
2023 Bi-weekly Premiums			
Employee	\$10.20	\$14.03	\$22.65
Employee + 1	\$25.81	\$34.01	\$54.81
Family	\$34.66	\$45.91	\$68.90

* Deductible applies with Premier and Out-of-Network providers

** When seeing an out-of-network provider, balance billing may occur resulting in an out-of-pocket expense.

*** Evidence-Based Integrated Care Plan (EBICP) provides additional cleaning(s) and/or fluoride treatments to individuals with specific medical conditions that have oral implications.