Delta Dental PPO℠ Platinum, Gold and Silver

Plans offered with 2- and 3-tier rate options.

This plan includes Delta Dental of Illinois' Enhanced Benefits Program. Please see our Enhanced Benefits Program brochure for more information.
To Go℠ can be offered with Delta Dental PPO℠ Platinum, Gold and Silver options. Please see our To Go℠ brochure for more information.

Summary of Coverages	Platinum Option			Gold Option			Silver Option		
Coverage A *Diagnostic:* • Routine exams twice per benefit year • Bitewing X-rays twice per benefit year • Full-mouth X-rays every three years *Preventive:* • Cleanings twice per benefit year • Fluoride treatments for children once per benefit year (to age 19) • Space maintainers (to age 14)	Delta Dental PPO℠ 100%*	Delta Dental Premier® 100%*	Non-Network 100%*	Delta Dental PPO℠ 100%*	Delta Dental Premier® 100%*	Non-Network 100%*	Delta Dental PPO℠ 100%*	Delta Dental Premier® 80%*	Non-Network 80%*
Coverage B *Basic Restorative:* • Sealants (to age 16) • Fillings, amalgam and composite (including posterior composites) *Non-Surgical Periodontics◆:* • Non-surgical treatment of gum disease *Endodontics◆:* • Root canals and pulpal therapy • Oral Surgery, Simple Extractions *Oral Surgery, Surgical Extractions◆* (including preoperative and postoperative care) ◆These benefits can be moved as a coverage grouping to Coverage C.	Delta Dental PPO 80%*	Delta Dental Premier 80%*	Non-Network 80%*	Delta Dental PPO 80%*	Delta Dental Premier 60%*	Non-Network 60%*	Delta Dental PPO 80%*	Delta Dental Premier 60%*	Non-Network 60%*
Coverage C *Major Restorative:* • Cast restorations: crowns, onlays and other ceramic restorations to permanent teeth • Implant therapy *Prosthodontics:* • Bridges, partial dentures and complete dentures *Surgical Periodontics* • Surgical treatment of gum disease	Delta Dental PPO 50%*	Delta Dental Premier 50%*	Non-Network 50%*	Delta Dental PPO 50%*	Delta Dental Premier 50%*	Non-Network 50%*	Delta Dental PPO 50%*	Delta Dental Premier 50%*	Non-Network 50%*
Coverage D *Orthodontics* (for children under age 19) Optional and available for all groups	Delta Dental PPO 50%*	Delta Dental Premier 50%*	Non-Network 50%*	Delta Dental PPO 50%*	Delta Dental Premier 50%*	Non-Network 50%*	Delta Dental PPO 50%*	Delta Dental Premier 50%*	Non-Network 50%*
Deductible Options	**Single** • $50 • $75	**Family** • $150 • $225		**Single** • $50 • $75	**Family** • $150 • $225		**Single** • $50 • $75	**Family** • $150 • $225	
	Applies to Coverages B & C only. Optional for Coverage A			Applies to Coverages B & C only. Optional for Coverage A			Applies to Coverages B & C only. Optional for Coverage A		
Annual Maximum Options	$1,000, $1,500 or $1,800			$1,000, $1,500 or $1,800			$1,000, $1,500 or $1,800		
Orthodontia Maximum Options Optional and available to all groups	$1,000 or $1,500			$1,000 or $1,500			$1,000, $1,500		

*In-network payment is based on discounted fees; Delta Dental Premier and out-of-network payment is based on Delta Dental of Illinois' Maximum Plan Allowance (MPA).

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