

TRUMAN STATE UNIVERSITY PLAN B (7620-2000) Benefit Summary¹	Delta Dental PPO SM 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 <u>while covered on this plan (Plan B)</u>, 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%
Subscriber Year Deductible (Applied to Basic and Major services)	\$50 per person		
Subscriber Year Maximum² (Applied to Preventive, Basic and Major)	\$1,000 per person		
Lifetime Orthodontic Maximum	\$1,500 per eligible dependent		
Dependent Age Limit: 26			

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 Dental benefits are provided according to a subscriber year benefit period, which begins on the date of your DDMO membership is effective and continues for 12 consecutive months. A new benefit period renews on the first day of your anniversary month.