Delta Dental of Indiana
Dental Benefit Highlights for
Health and Hospital Corporation of Marion County #1060

Delta Dental PPO™ (Point-of-Service) *Coverage effective January 1, 2025*	Plan A			Plan B			Plan C		
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
	Member Pay	Member Pay	Member Pay	Member Pay	Member Pay	Member Pay	Member Pay	Member Pay	Member Pay
Diagnostic & Preventive									
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	0%	0%	20%	0%	0%	20%	0%	0%	10%
Sealants - to prevent decay of permanent teeth	0%	0%	20%	0%	0%	20%	0%	0%	10%
Brush Biopsy - to detect oral cancer	0%	0%	20%	0%	0%	20%	0%	0%	10%
Radiographs - X-rays	0%	0%	20%	0%	0%	20%	0%	0%	10%
Basic Services									
Emergency Palliative Treatment - to temporarily relieve pain	40%	40%	50%	30%	30%	40%	20%	20%	30%
Minor Restorative Services - fillings and crown repair	40%	40%	50%	30%	30%	40%	20%	20%	30%
Endodontic Services - root canals	40%	40%	50%	30%	30%	40%	20%	20%	30%
Periodontic Services - to treat gum disease	40%	40%	50%	30%	30%	40%	20%	20%	30%
Oral Surgery Services - extractions and dental surgery	40%	40%	50%	30%	30%	40%	20%	20%	30%
Other Basic Services - misc. services	40%	40%	50%	30%	30%	40%	20%	20%	30%
Major Services									
Major Restorative Services – crowns	75%	75%	75%	50%	50%	60%	40%	40%	50%
Relines and Repairs – to bridges and dentures	75%	75%	75%	50%	50%	60%	40%	40%	50%
Prosthodontic Services – bridges and dentures	75%	75%	75%	50%	50%	60%	40%	40%	50%
Implants	100%	100%	100%	100%	100%	100%	40%	40%	50%
Orthodontic Services									
Orthodontic Services - braces	50%	50%	50%	50%	50%	50%	40%	40%	50%
Orthodontic Age Limit -	**treatment for dependent children must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached**			**treatment for dependent children must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached**			**No Age Limit**		
Lifetime Orthodontic Maximum	**$500 per person total per lifetime on orthodontic services**			**$1,000 per person total per lifetime on orthodontic services**			**$1,500 per person total per lifetime on orthodontic services**		
Waiting Period	**None**			**None**			**None**		

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the member portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

Maximum Payment –

Plan A - $1,000 per person total per Benefit Year on all services except orthodontic services. $500 per person total per lifetime on orthodontic services.

Plan B - $1,250 per person total per Benefit Year on all services except orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Plan C - $2,500 per person total per Benefit Year on all services except orthodontic services. $1,500 per person total per lifetime on orthodontic services.

Maximum Carryover – If at least one Covered Service is applied toward your Maximum Payment in a Benefit Year and the total Benefit paid does not exceed $500.00 in that Benefit Year, up to $250.00 will carry over to the next Benefit Years Maximum Payment. This carryover amount will accumulate from one Benefit Year to the next, but will not exceed $1,000.00. If no Covered Services are paid during a Benefit Year, all accumulated carryover amounts from previous Benefit Years will be forfeited.

Deductible – $50 deductible per person total per Benefit Year limited to a maximum deductible of $150 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services.

Note – *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*