Ascension Dental Plans Administered Through Delta Dental of MO 2024
INCENTIVE PPO PLANS

	Base Benefit			Comprehensive			Comprehensive Plus		
Covered Services & Limitations How Many/How Often	**PPO Network**	**Premier Network**	**Out of Network**	**PPO Network**	**Premier Network**	**Out of Network**	**PPO Network**	**Premier Network**	**Out of Network**
Dependent Age	Age 26 - Birthdate			Age 26 - Birthdate			Age 26 - Birthdate To Age 19 for orthodontia		
Annual Deductible (does not apply to Type A services)									
Individual	NONE			$25	$25	$25	$25	$25	$50
Family				$75	$75	$75	$75	$75	$150
Type A Preventative									
Periodic Exams - 2 per Benefit Period	100%	100%	80%	100%	100%	80%	100%	100%	80%
Bitewing X-rays 1 per Benefit Period	100%	100%	80%	100%	100%	80%	100%	100%	80%
Full mouth X-rays/Panoramic X-rays - 1 per 3 Benefit Periods (adults and children over age 6)	100%	100%	80%	100%	100%	80%	100%	100%	80%
Periodontal Cleanings - 4 per Benefit Period Combined with regular cleanings (i.e. 4 cleanings TOTAL per Benefit Period)	100%	100%	80%	100%	100%	80%	100%	100%	80%
Fluoride Treatment - 1 per Benefit Period under the age of 19	100%	100%	80%	100%	100%	80%	100%	100%	80%
Space Maintainers - (1 per Lifetime per Quadrant to age 19)	100%	100%	80%	100%	100%	80%	100%	100%	80%
Sealant - 1 per 3 Benefit Periods for caries free first and second permanent molars up to age 16	100%	100%	80%	100%	100%	80%	100%	100%	80%
Brush Biopsy	100%	100%	80%	100%	100%	80%	100%	100%	80%
Palliative Treatment (emergency treatment for pain)	100%	100%	80%	100%	100%	80%	100%	100%	80%
Type B Basic Restorative									
Amalgam or Composite fillings	60%	50%	40%	60%	50%	40%	85%	80%	60%
Periodontics	60%	50%	40%	60%	50%	40%	85%	80%	60%
Endodontics	60%	50%	40%	60%	50%	40%	85%	80%	60%
Extractions	60%	50%	40%	60%	50%	40%	85%	80%	60%
Oral Surgery and General Anesthesia	60%	50%	40%	60%	50%	40%	85%	80%	60%
Osseous Surgery (no frequency limitations)	60%	50%	40%	60%	50%	40%	85%	80%	60%
Surgical Biopsy	60%	50%	40%	60%	50%	40%	85%	80%	60%
Type C - Major Restorative									
Initial Bridge, First Installation of Full or Partial Dentures, and Adding Teeth	NO COVERAGE			50%	50%	40%	50%	50%	40%
Replacement or Alteration of Dentures of Fixed Bridge - 1 per 5 Benefit Periods				50%	50%	40%	50%	50%	40%
Replacement of Full Denture - 1 per 5 Benefit Periods				50%	50%	40%	50%	50%	40%
Repair of Bridges and Dentures				50%	50%	40%	50%	50%	40%
Relining Dentures				50%	50%	40%	50%	50%	40%
Crowns and Buildup for Crowns - 1 per 5 Benefit Periods				50%	50%	40%	50%	50%	40%
Implant Coverage - 1 per 5 Benefit Periods				50%	50%	40%	50%	50%	40%
Harmful Habits (Bruxism) - 1 per Lifetime				50%	50%	40%	50%	50%	40%
Type D - Orthodontia									
Orthodontia (Children covered as dependents under the plan to age 19)	NO COVERAGE - child or adult			NO COVERAGE - child or adult			50% child coverage $1,500 lifetime maximum No adult coverage		
Orthodontia payments are paid on a quarterly basis									
Orthodontic benefits end at cancellation of coverage									
Maximum Benefits									
*Type A services will not be applied toward the annual maximum.	$500			$1,500			$2,000 (excludes Orthodontia)		
Orthodontia Lifetime Maximum	No coverage - child or adult			No coverage - child or adult			$1,500		
TMJ	NO COVERAGE			NO COVERAGE			NO COVERAGE		

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents the majority of the services within each category, but is not a complete description of the Plan. A summary plan description will be made available following your plan's effective date and will govern if any discrepancies exist between this overview and the actual summary plan description.