

NORTHWEST MISSOURI STATE UNIVERSITY Benefit Summary¹	Delta Dental PPO™ 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 <ul style="list-style-type: none"> Oral exams, twice per calendar year Prophylaxis (cleanings) twice per calendar year Periapical x-rays, as required Bitewing x-rays, two sets per benefit period Full mouth x-rays, once in any 36-month period Space maintainers, as required Topical fluoride treatments for dependent children under age 19, once per calendar year 	100%	100%	100%
Basic services <ul style="list-style-type: none"> Emergency palliative treatment Periodontal maintenance, twice per calendar year (subject to the prophylaxis frequency limitation) Sealants for dependent children to age 17, once in any 36 months per tooth Fillings, composite (white) on anterior teeth and amalgam (silver) on posterior teeth Simple and surgical extractions Crown and bridge repairs & recement Denture repairs & adjustments General Anesthesia, in conjunction with a covered surgical procedure Stainless steel crowns, once in 5 years per tooth 	80%	80%²	70%
Major services <ul style="list-style-type: none"> Non-surgical and surgical periodontics Endodontics Bridges, once in 5 years Crowns, Inlays, Onlays, once in 5 years Dentures, once in 5 years <p><i>Implants are not a covered benefit; however, an alternate benefit allowance will be provided based on the cost of a removable partial</i></p>	50%	50%	50%
Orthodontia Orthodontia for all eligible participants	50%	50%	50%
Calendar year deductible (Applied to Basic and Major services)	\$50 per person		
Annual maximum (Applied to Preventive, Basic and Major services)	\$1,000 per person		
Orthodontia lifetime maximum	\$1,000 per person		
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 Effective January 1, 2025 Basic Services received by a Delta Dental Premier® provider will be covered at 80%. Previously covered at 70%.

