

ROOFERS LOCAL UNION 241

2024 DENTAL ELECTION FORM

The Delta Dental DMO dental plan contains in-network only benefits. Members must seek care from participating providers or the claim will not be paid. It is the member's responsibility to confirm the providers they are seeing participating in the network.

The Delta Dental PPO dental plan offers in- and out-of-network coverage, which allows you greater freedom of choice. By selecting in-network benefits you can utilize a large network of participating dentists who accept the Delta Dental PPO Contracted Fee as payment in full after deductible and coinsurance. Out-of-Network benefits are reimbursed based on the Delta Dental Maximum Allowable Charge (MAC) for the procedure performed. Out-of-Network providers may not accept MAC as payment in full and may balance bill without Limit

Benefit	DMO		PPO	
	In-Network Only		In-Network	Out-of-network
General Plan Information				
Deductible Accumulation Period	Calendar Year (Jan 1 – Dec 31)		Calendar Year (Jan 1 – Dec 31)	
Dependent Age Limit	To Age 26		To Age 26	
Network	Delta DMO Network		PPO II Network	N/A
Reimbursement Level	Delta DMO Contracted Fee		Delta PPO Contracted Fee	Delta Maximum Allowable Charge
Calendar Year Deductible				
Per Person	N/A		\$50	
Family Max	N/A		\$150	
Deductible Waived For	N/A		Preventive / Diagnostic Services	
Calendar Benefit Maximum				
Per Person	N/A		\$1,750	
Waiting Period				
Major Services	N/A		N/A	
Preventive Services				
Routine Exams	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Prophylaxis (cleanings)				
Fluoride Treatments (to age 16)				
Sealants (to age 16)				
Space Maintainers (to ae 16)				
Diagnostic Services				
X-Rays	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Lab & Other Diagnostic Tests				
Basic Services				
Amalgam & Composite Fillings	Per Delta Fee Schedule	Covered 90% after Deductible	Covered 90% after Deductible	Covered 90% after Deductible
Palliative Treatment				
General Anesthesia				
Simple Extractions				
Oral Surgery				
Periodontics				
Endodontics				
Major Services				
Crowns	Per Delta Fee Schedule	Covered 50% after Deductible	Covered 50% after Deductible	Covered 50% after Deductible
Inlays				
Onlays				
Dentures				
Bridges				
Orthodontic Services				
	Not Covered	Not Covered	Not Covered	Not Covered
Monthly Premium				
Employee Only	\$15.28		\$22.51	
Double (EE and Spouse or EE and 1 Child)	\$29.68		\$43.83	
Family	\$47.80		\$72.02	

Plan Election

- Delta DMO Dental
 Delta PPO Dental
 Waive Dental Coverage
 Employee Only
 Double
 Family

_____ Employee Name (print)
 _____ Employee Signature
 _____ Social Security Number
 _____ Date