ROOFERS LOCAL UNION 241
2026 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	$2,500	
Waiting Period			
Major Services	N/A	N/A	
Preventive Services			
Routine Exams	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%
Lab & Other Diagnostic Tests			
Basic Services			
Amalgam & Composite Fillings	Per Delta Fee Schedule	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
Inlays			
Onlays			
Dentures			
Bridges			
Implants – ***Not Covered under DMO***			
Orthodontic Services			
	Not Covered	Not Covered	Not Covered
Monthly Premium			
Employee Only	$15.28	$24.35	
Double (EE and Spouse or EE and 1 Child)	$29.68	$47.41	
Family	$47.80	$77.90	

Plan Election

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

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