Renaissance Dental DPPO

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible (if applicable).

	Elite Plan In-Network	Enhanced Plan In-Network	Essential Plan In-Network
Plan Year Deductible	$50 Individual / $150 Family		
Maximum Annual Benefit	$1,500 Per Individual	$1,000 Per Individual	$1,000 Per Individual
Preventive & Diagnostic Services Exams Cleanings Fluoride Bitewing X-Rays	Covered 100%		
Basic Services Fillings Non-Surgical Extractions Oral Surgery	Covered 80% after deductible	Covered 80% after deductible	Covered 50% after deductible
Major Services Bridges Crowns Periodontic Endodontic	Covered 50% after deductible	Covered 50% after deductible	Covered 25% after deductible
Orthodontic Services - Dependents to Age 19	Covered 50% after deductible	Not Covered	
Orthodontic Lifetime Maximum Benefit	$1,000 per individual	Not Covered	

The table above illustrates your in-network benefits in summary only. For a complete description of benefits, coverages, limitations, and exclusions, consult your plan documents

YOUR MONTHLY BENEFIT COSTS

	Elite Plan	Enhanced Plan	Essential Plan
EMPLOYEE	$37.62	$31.49	$20.75
TWO-PARTY	$68.52	$57.20	$37.74
FAMILY	$107.30	$89.55	$59.05