

Dental Benefits At-A-Glance

This is a highlight of the benefits only. Refer to your member certificate or group subscriber agreement for specific details, including limitations and exclusions.

	Delta Dental of New Mexico	
	Delta Preferred Option	Delta Dental Premier
Annual Benefit Maximum (per plan year)	\$1,500 per person	
Deductible	\$50 per person, \$150 family (lifetime max)	
Lifetime Orthodontic Benefit Maximum	\$1,200 per person	
Diagnostic/Preventive		
Routine cleanings/exams (2 per year)	Plan pays 100% no deductible applies ¹	Plan pays 80%, no deductible applies ¹
Bitewing x-rays (2 per year)		
Fluoride treatment		
Sealants		
Emergency treatment for the relief of pain		
Full mouth x-rays (1 complete set every 5 years)		
Basic		
Fillings	Plan pays 85% subject to deductible ²	Plan pays 85% subject to deductible ²
Stainless steel crowns		
Root canal therapy		
Non-surgical and surgical periodontics		
Complex oral surgery		
General anesthesia (in conjunction with oral surgery)		
Prescription medications for dental related conditions		
Major		
Crowns (only when teeth cannot be restored with a filling)	Plan pays 50% subject to deductible ³	Plan pays 50% subject to deductible ³
Removable partial or complete dentures		
Fixed bridge		
Orthodontic		
Diagnostic, active and retention treatment for adults and children	Plan pays 50%	Plan pays 50%

¹ Topical fluoride through age 18, twice in a calendar year. Sealants through age 16; permanent molars only; 3 year limitation.

² (2 per year) for routine cleanings / exams means twice in a calendar year.

³ Amalgam fillings on anterior or posterior teeth; composite resin fillings for anterior teeth only. Stainless steel crowns for primary teeth. Endodontics coverage includes pulp therapy and root canal filling. General Anesthesia and intravenous sedation are eligible expenses when dentally necessary and administered by a licensed provider for a covered oral surgery procedure.

⁴ includes procedures for construction or repair of crowns, cast restorations, bridges, partials or complete dentures.

Note: benefit percentages shown above are based on the dentist's billed amount, subject to maximums per the applicable network fee schedule. Additional out-of-pocket costs will apply to non-network providers.

United Concordia³

Concordia Flex (High)	Concordia Preferred (Low)	
\$1,500 per person	\$1,000 per person	
\$50 individual, \$150 family (lifetime max)	\$25 per person per plan year, \$75 family	
\$1,200 per person	Not covered	
Diagnostic/Preventive	Network	Out-of-Network
Plan pays 100% of allowable amount, no deductible applies ⁴	Plan pays 80% of allowable amount, no deductible applies ⁴	Plan pays 25% of allowable amount after deductible ⁴
Basic		
Plan pays 85% of allowable amount after deductible*	Plan pays 80% of allowable amount after deductible*	Not covered
	Plan pays 25% of allowable amount after deductible (oral surgery)	
	Not covered (general anesthesia and prescription medications)	
Major		
Plan pays 50% of allowable amount after deductible	Plan pays 25% after deductible	Not covered
Orthodontic		
Plan pays 50% up to lifetime maximum	Not covered	Not covered

*Amalgam fillings on posterior teeth. Composite resin fillings for anterior teeth only.

⁴Flouride: 2 per year up to age 19. Sealants: permanent molars only.