DELTA DENTAL®

PPO Plus Premier™ Voluntary 3
10-50 Enrolled Employees
Benefit Summary

Plan Highlights

	PPO	Premier® and Out-of-Network
Calendar Year Deductible Per person/per family (excluding P&D)	$50 / $150	
Calendar Year Maximum (Per enrollee)	$1,500	$1,000
Waiting Period	None	
Orthodontics	Not covered	

Benefits

Preventive & Diagnostic	Frequency	Coverage* PPO / Premier / Out-of-Network
Oral Exams and Evaluations Consultations - combined with all other exams Emergency exams - combined with all other exams	2 per calendar year	100%
Cleanings/Prophylaxis	2 per calendar year	
Bitewing X-rays	2 per calendar year (through age 18) 1 per calendar year (age 19 and older)	
Full mouth X-rays or panoramic film	1 per 5 years	
Sealants	Once in a 24-month period per tooth (dependents through age 14) on permanent molars with no prior restorations on the "O" surface. Not covered in addition to resin fillings.	
Topical fluoride	2 per calendar year (through age 18)	
Space maintainers	1 per arch per lifetime (through age 13)	
Basic Services		
Fillings	Repeat restorations of same surface payable once in 2 years	80%
Composite/resin restorations on second bicuspids and molars (white fillings)	Composite resin restorations will be covered on all teeth	
Simple Extractions	1 per lifetime per tooth	
Root Canal Therapy (Endodontics)	1 per lifetime per tooth	
Periodontal Maintenance	2 per calendar year. Periodontal maintenance is interchangeable with, but not in addition to, routine cleanings	
Scaling and Root Planing	1 per 2 years per quadrant.	
Periodontal surgeries (gingivectomy, osseous surgery, flap surgery and grafts, etc.)	1 per 3 years per quadrant. Note, frequencies vary by procedure code.	
Oral Surgery	Frequencies vary by procedure code. If performed within 6 months of a major restoration or endodontic procedure no further benefits provided for the extraction.	
General Anesthesia or IV sedation	Payable with covered oral surgery	

*Members will be subject to balance billing for covered services. PPO Dentist: Coverage percent is based on the PPO Schedule of Fees. Premier: Coverage percent is based on the Participating Dentist Maximum Approved Charge (PMAC). Non-participating: Coverage percent is based on the Non-Participating Dentist Maximum Approved Charge (NMAC).

Benefits, continued

Major Services	Frequency	Coverage* PPO / Premier / Out-of-Network
Single Crowns	Replacement 1 in 5 years against itself or any other major services on the same tooth.	50%
Stainless Steel Crowns	Replacement 1 in 2 years	
Crown inlay, onlay and veneer repairs	No frequency limitations	
Crown recements	Payable 6 months after insertion then 1 in 12 months	
Post and Core	Replacement 1 in 5 years	
Inlays	Given alternate benefit of a composite filling	
Inlays/Onlays	If inlays are payable replacement 1 in 5 years; onlays are payable 1 in 5 years	
Implants	Once every 60 months per tooth for ages 16 and older	
Bridgework (abutment crowns and pontics)	1 per 5 years	
Recements	Not billable when performed within 6 months of initial placement by the same dentist/dental office, but then payable 1 per 12 months	
Repairs	Not billable within 12 months of the initial placement, but then payable 2 per 3 years.	
Dentures (complete and partials)	1 placement per 5 years	
Adjustments	Not billable when performed within 6 months of the initial placement by the same dentist/dental office, but then payable 2 in 12 months	
Repairs, relines and rebases	Not billable when performed within 6 months of the initial placement by the same dentist/dental office, but then payable 1 in 6 months	

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Need help?

Visit DeltaDentalCT.com to find a participating dentist or DeltaDentalCT.com/MySmile to print your ID card.

For benefits or claims questions, call **800-452-9310.**

This overview contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of Connecticut, Inc. which governs the benefits and operation of your program. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this overview.

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Calendar Year Deductible Per person/per family (excluding P&D)	$50 / $150	
Calendar Year Maximum (Per enrollee)	$2,000	$1,500
Waiting Period	None	
Orthodontics	Not covered	

Benefits

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