

Plan Highlights

| | PPO | Premier® and Out-of-Network |
|--------------------------------------|-----|-----------------------------|
| Calendar Year Deductible | | \$0 |
| Calendar Year Maximum (Per enrollee) | | \$500 |
| 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) | |

*Members will be subject to billing for the difference between the PPO Approved Fee and the Participating Dentist Maximum Approved Charge (PMAC). Coverage percent is based on the PPO Schedule of Fees.

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.