

#### Plan Highlights

|                                                                       | PPO                         | Premier® and Out-of-Network |
|-----------------------------------------------------------------------|-----------------------------|-----------------------------|
| <b>Calendar Year Deductible</b> Per person/per family (excluding P&D) | \$50 / \$150   \$75 / \$225 |                             |
| <b>Calendar Year Maximum</b> (Per enrollee)                           | \$1,000                     |                             |
| <b>Waiting Period</b>                                                 | None                        |                             |
| <b>Orthodontics</b>                                                   | Not covered                 |                             |

#### Benefits

| Preventive & Diagnostic                                                                                                              |                                                                                                                                                                                        | Frequency  | Coverage*<br>PPO / Premier / Out-of-Network |
|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|---------------------------------------------|
| Oral Exams and Evaluations<br>Consultations - combined<br>with all other exams<br>Emergency exams - combined<br>with all other exams | 2 per calendar year                                                                                                                                                                    | 100% / 80% |                                             |
| Cleanings/Prophylaxis                                                                                                                | 2 per calendar year                                                                                                                                                                    |            |                                             |
| Bitewing X-rays                                                                                                                      | 2 per calendar year (through age 18)<br>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<br>(dependents through age 14) on permanent<br>molars with no prior restorations on the "O"<br>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<br>once in 2 years                                                                                                                         | 80% / 60%  |                                             |
| Composite/resin restorations on second<br>bicuspid and molars (white fillings)                                                       | Composite resin restorations will be covered on<br>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<br>interchangeable with, but not in addition to,<br>routine cleanings                                                                  |            |                                             |
| Scaling and Root Planing                                                                                                             | 1 per 2 years per quadrant.                                                                                                                                                            |            |                                             |
| Periodontal surgeries (gingivectomy, osseous<br>surgery, flap surgery and grafts, etc.)                                              | 1 per 3 years per quadrant. Note, frequencies vary<br>by procedure code.                                                                                                               |            |                                             |
| Oral Surgery                                                                                                                         | Frequencies vary by procedure code. If<br>performed within 6 months of a major restoration<br>or endodontic procedure no further benefits<br>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*<br>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?



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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.

