

### Plan Highlights

	PPO	Premier® and Out-of-Network
<b>Calendar Year Deductible</b> Per person/per family (excluding P&D)		\$0
<b>Calendar Year Maximum</b> (Per enrollee)		\$750
<b>Waiting Period</b>		None
<b>Orthodontics</b>		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.

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.

### Need help?

 Visit [DeltaDentalCT.com](http://DeltaDentalCT.com) to find a participating dentist or [DeltaDentalCT.com/MySmile](http://DeltaDentalCT.com/MySmile) to print your ID card.

 For benefits or claims questions, call [800-452-9310](tel:800-452-9310).

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