

2-9 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) | \$1,000 | |
| Waiting Period | None | |
| Orthodontics | No | t covered |

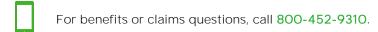
Benefits

| 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 | | |
| Cleanings/Prophylaxis | 2 per calendar year | | |
| Bitewing X-rays | 2 per calendar year (through age 18) 1 per calendar year (age 19 and older) | | |
| ull mouth X-rays or panoramic film 1 per 5 years | | 100% | |
| 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 | | |
| 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 | 80% | |
| Periodontal Maintenance | 2 per calendar year. Periodontal maintenance is interchangeable with, but not in addition to, routine cleanings | | |
| Scaling and Root Planing | ng 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 | Anesthesia or IV sedation Payable with covered oral surgery | | |

^{*}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?



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