

PPO Plus Premier™ 2

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 / \$750	
Waiting Period	None	
Orthodontics	No	t covered

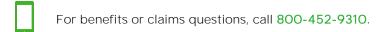
Benefits

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		
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		100%	
			Sealants
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		
Periodontal Maintenance	2 per calendar year. Periodontal maintenance is interchangeable with, but not in addition to, routine cleanings	80%	
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	al 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).

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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