DELTA DENTAL

DELTA DENTAL PREMIER® FOR SMALL BUSINESSES – ENHANCED PLAN
BENEFITS SUMMARY

HealthSourceRI
YOUR HEALTH. YOUR WAY.

This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the *Certificate of Coverage* for the full plan terms. The Certificate includes any limitations or exclusions not seen here. To be covered, services must be *dentally necessary* and appropriate as per *our* review guidelines.

UNDER AGE 19

MAXIMUMS	
Annual Maximum	None
Medically Necessary Orthodontic Lifetime Maximum	None
Maximum Lifetime Cap	Unlimited
In Network Out-of-Pocket Maximum (per member)	$350 for one individual under age 19 / $700 for two or more individuals under age 19
Out-of-Network Out-of-Pocket Maximum (per member)	None

DEDUCTIBLES
Apply to certain services

Deductible: $50 per member

P Indicates Pre-treatment Estimate recommended.

A Indicates Prior Authorization required.

D Indicates Deductible applies.

Procedure	In Network	Out of Network*	Frequency / Limitations+
Diagnostic			
Oral Exam	100%	100%	Twice per calendar year
Bitewing x-rays	100%	100%	Two sets per calendar year
Complete x-ray series or panoramic film	100%	100%	Once every 60 months
Single x-rays	100%	100%	As required
Preventive			
Cleaning	100%	100%	Twice per calendar year
Fluoride treatment	100%	100%	Twice per calendar year
Sealants	100%	100%	Once every 24 months on unrestored permanent molars
Space maintainers	100%	100%	Once every 60 months for lost deciduous (baby) teeth
Minor Restorative			
Amalgam (silver) fillings and composite (white) fillings	75% D	75% D	
Repairs to existing partial or complete dentures	75% D	75% D	Once per calendar year
Recementing crowns or bridges	75% D	75% D	Once every 60 months
Rebasing or relining of partial or complete dentures	75% D	75% D	Once every 60 months

AGE 19 & OVER

MAXIMUMS	
Annual Maximum	$1,750
Maximum Lifetime Cap	Unlimited

DEDUCTIBLES
Apply to certain services

Deductible: $50 per member

P Indicates Pre-treatment Estimate recommended.

D Indicates Deductible applies.

Procedure	In Network	Out of Network*	Frequency / Limitations+
Diagnostic			
Oral Exam	100%	100%	Twice per calendar year
Bitewing x-rays	100%	100%	One set per calendar year
Complete x-ray series or panoramic film	100%	100%	Once every 60 months
Single x-rays	100%	100%	As required
Preventive			
Cleaning	100%	100%	Twice per calendar year
Minor Restorative			
Amalgam (silver) fillings and composite (white) fillings	75% D	75% D	
Repairs to existing partial or complete dentures	75% D	75% D	Once per calendar year
Recementing crowns or bridges	75% D	75% D	Once every 60 months
Rebasing or relining of partial or complete dentures	75% D	75% D	Once every 60 months

DELTA DENTAL PREMIER® FOR SMALL BUSINESSES – ENHANCED PLAN BENEFITS SUMMARY (Continued)

UNDER AGE 19

Procedure	In Network	Out of Network*	Frequency / Limitations⁺
Major Restorative			
P Crowns, build ups, posts and cores	50% D	50% D	Covered over natural teeth when teeth cannot be restored with regular fillings. Replacement limited to once every 60 months.
Endodontics			
Root canal therapy	75% D	75% D	
Periodontics			
Periodontal maintenance following active therapy	50% D	50% D	Twice per calendar year
P Root planing and scaling	50% D	50% D	Once per quadrant every 24 months
P Osseous (bone) surgery	50% D	50% D	Once per quadrant every 36 months (bone grafts are not covered)
P Gingivectomies	50% D	50% D	Once per site every 36 months
P Soft tissue grafts	50% D	50% D	Once per site every 60 months
P Crown lengthening	50% D	50% D	Once per site every 60 months
Prosthodontics			
P Bridges and crowns over implants	50% D	50% D	Replacement limited to once every 60 months
P Partial and complete dentures	50% D	50% D	Replacement limited to once every 60 months
P Surgical placement of endosteal implant and abutment	50% D	50% D	Once per tooth site per lifetime
Extractions and Oral Surgery			
Extractions and other routine oral surgery when not covered by a patient's medical plan	75% D	75% D	
Orthodontics			
A Medically necessary braces and related services	50%	50%	**Requires prior authorization.** No payment will be made if not obtained. Covered only when medically necessary. Patient must have severe and handicapping malocclusion as defined by our guidelines. Once per lifetime.
Other Services			
Palliative treatment (minor procedures necessary to relieve acute pain)	75% D	75% D	Twice per calendar year
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	75% D	75% D	
Occlusal guards	50% D	50% D	Once every 12 months. Not covered when used as an athletic mouth guard.
Dependent children are covered under these benefits up until the end of the month that they turn age 19.			

AGE 19 & OVER

Procedure	In Network	Out of Network*	Frequency / Limitations⁺
Major Restorative			
P Crowns, build ups, posts and cores	50% D	50% D	Covered over natural teeth when teeth cannot be restored with regular fillings. Replacement limited to once every 60 months.
Endodontics			
Root canal therapy	75% D	75% D	
Periodontics			
Periodontal maintenance following active therapy	50% D	50% D	Twice per calendar year
P Root planing and scaling	50% D	50% D	Once per quadrant every 24 months
P Osseous (bone) surgery	50% D	50% D	Once per quadrant every 36 months (bone grafts are not covered)
P Gingivectomies	50% D	50% D	Once per site every 36 months
P Soft tissue grafts	50% D	50% D	Once per site every 60 months
P Crown lengthening	50% D	50% D	Once per site every 60 months
Prosthodontics (6 month waiting period)			
P Bridges and crowns over implants	50% D	50% D	Replacement limited to once every 60 months
P Partial and complete dentures	50% D	50% D	Replacement limited to once every 60 months
P Surgical placement of endosteal implant and abutment	50% D	50% D	Once per tooth site per lifetime
Extractions and Oral Surgery			
Extractions and other routine oral surgery when not covered by a patient's medical plan	75% D	75% D	
Other Services			
Palliative treatment (minor procedures necessary to relieve acute pain)	75% D	75% D	Twice per calendar year
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	75% D	75% D	
Dependent children covered under a family plan are covered under these benefits from age 19 up until the end of the month that they turn age 26. Children under age 19 have different coverage.			

***Out-of-network care:** This is the amount Delta Dental pays. For services received out-of-network, *your* costs will be greater. *Non-participating dentists* are paid at a reduced level. Please refer to *your Certificate of Coverage* for further details.

⁺**Time limits** on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.