DELTA DENTAL®

Benefit Highlights

PPSD LOCAL 1339 CLERKS

Product Name: Delta Dental PPO Plus Premier™
Plan Type: National Coverage

The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%,80%) . Your group number is **1105-0027, 0028**. **Coverage for benefits with time limitations (i.e. 6,12,24,36 or 60 months) is calculated to the exact day.**

The annual maximum is: $2,000.00 per member per calendar year
The annual deductible is: $0.00
The maximum lifetime cap: Unlimited
Pretreatment estimates are recommended for underlined procedures.

"Certain oral surgery procedures do not count towards the annual maximum."

Plan pays 100%; Member Coinsurance 0%

- Oral exam - twice per calendar year
- Cleaning - twice per calendar year
- Fluoride treatment - for children under age 19 twice per calendar year
- Bitewing x-rays - one set per calendar year
- Complete x-ray series or panoramic film once every 60 months
- Single x-rays as required
- Sealants for children under age 14, once every 24 months on unrestored permanent molars
- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) and composite (white) fillings.
- Space maintainers once every 60 months for lost deciduous (baby) teeth
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy on permanent teeth - one procedure per tooth per lifetime. Vital pulpotomy and apicoectomies also covered once per tooth per lifetime.
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Periodontal maintenance following active therapy - two per year
- Root planing and scaling once per quadrant every 24 months.
- Osseous (bone) surgery once per quadrant every 36 months (bone grafts are not covered).
- Gingivectomies once per site every 36 months.
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months

Plan pays 80%; Member Coinsurance 20%

- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months
- Bridges and crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months
- Surgical placement of endosteal implant and abutment, once per tooth site per lifetime

Plan pays 50%; Member Coinsurance 50%

- Surgical placement of endosteal implant and abutment, once per tooth site per lifetime.

Orthodontics: Plan pays 50%; Member Coinsurance 50%

- Elective braces and related services for dependent children under the age of 26. Subject to a lifetime maximum. No pre-approval required.

Lifetime maximum (orthodontics only) is $2,000.00

Dependent coverage - Dependent children are covered up until the end of the month that they turn age 26.

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Exclusions & Limitations

Unless specifically covered by your dental plan, the following are not covered:

- Services that are not dentally necessary and appropriate according to our review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; orthodontics; and oral surgery. We will make a decision whether a service is dentally necessary based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a dentist. Our guidelines can be found on our website at **www.deltadentalri.com**. You can have your dentist send us a request for a pre-treatment estimate in advance of the service to see if the service meets our guidelines.
- Services greater than the annual maximum.
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- An illness or injury that Delta Dental decides is employment-related.
- Services you would not have to pay for if you did not have this Delta Dental coverage.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done by a dentist who is a member of your immediate family.
- An illness, injury or dental condition for which benefits are, or would have been available, through a government program if you did not have this Delta Dental coverage.
- Services done by someone who is not a licensed dentist or a licensed hygienist working as authorized by applicable law.
- Exams by specialists, except for periodic oral exams.
- Consultations.
- Disorders related to the temporomandibular joints (TMJ), including night guards and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations needed because of teeth grinding or due to erosion, abrasion or attrition.
- Services done mainly to change or to improve your appearance.
- Occlusal guards.
- Implants.
- Bone grafts.
- Splinting and other services to stabilize teeth.
- Laboratory or bacteriological tests or reports.
- Temporary, complete dentures or temporary, fixed bridges or crowns.
- Prescription drugs.
- Guided tissue regeneration.
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.
- General anesthesia or intravenous sedation given by anyone other than a dentist.

Delta Dental can adopt; and, apply, policies that we deem reasonable when we approve the eligibility of subscribers; and, the appropriateness of treatment plans and related charges.

All claims must be filed within one year of the date of service.

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