DELTA DENTAL®

PPO Voluntary 6
10-50 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	6 months basic	
Orthodontics	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)	
Basic Services		
Fillings	Repeat restorations of same surface payable once in 2 years	80%
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	
Scaling 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	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 New Jersey, 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 DeltaDentalNJ.com to find a participating dentist or DeltaDentalNJ.com/MySmile to print your ID card.

For benefits or claims questions, call **800-452-9310.**

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Calendar Year Maximum (Per enrollee)	$1,250	
Waiting Period	6 months basic	
Orthodontics	Not covered	

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